Maternal and Child Health Services
Title V Block Grant

State Narrative for Utah

Application for 2014
Annual Report for 2012

Document Generation Date: Thursday, July 11, 2013

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Utah Department of Health has submitted the Assurances and Certifications to the authorized signatory and has on file the signed Assurances and Certifications dated July, 2012. The State Title V Office has on file a copy of the Assurances and Certifications non-construction program, debarment and suspension, drug free work place, lobbying program fraud, and tobacco smoke. They are available at any time for review upon request. The state Title V agency is compliant with all the federal regulations governing the Title V funding allocated to Utah.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Public Input Process FY2014

Public input is a valued part of the annual MCH Block Grant application process. In April 2013, the Utah Maternal and Child Health Bureau announced to the public and stakeholders through various mechanisms that the Utah Department of Health, Division of Family Health and Preparedness was soliciting public input for FY14 MCH Block Grant Application. The Utah Department of Health is the designated Title V agency for Utah.

Newspaper Ads/Public Notices
Public notices were published in major newspapers throughout the state on 4/17/13. The announcement noted that the Division of Family Health and Preparedness is responsible for administration of the MCH Block Grant received by the State of Utah under the provisions of Title V of the federal Social Security Act. Under this capacity, the Division is required annually to submit an application to the U.S. Department of Health and Human Services. The public notices announce that the proposed program activities related to annual goals for the Fiscal Year 2014 MCH Block Grant Application and Report were available for public review and comment.

Website Posting/Web Application
The proposed program activities were posted online at the following internet site: http://www.health.utah.gov/mch/mchblock.php. This link directed the user to the FY2014 Annual Goals webpage. The webpage outlined the proposed activities targeted for the three MCH populations (pregnant women & infants, children & youth, and children & youth with special health care needs). An email containing this web URL was sent to an extensive list of stakeholders including: parents, consumers, health care providers, academia, community-based advocacy organizations, community health clinics, local health departments, and various government agencies requesting input and feedback.

We have continued to make modifications in the web application to enhance system usability. The online comments were accepted between April 17 and May 10, 2013. We have received valuable feedback on community needs and emerging issues as well as reaffirmation of the importance of current program activities. Same as last year, we used web reporting tool Google Analytics to report our web trends. We had 234 visits, 190 unique visitors, and 522 page views during the public comment period.

UBID System
We have made several modifications to our Utah Block Grant Information Database (UBID) system. This customized system was developed by the Data Resources Program and was intended to make the coordination and collection of required information from 36 individuals from various public health programs more efficient. The UBID system allowed us to capture and maintain information in one single location. This year we have developed a UBID Step by Step User Manual to assist our block grant contributors with data and narrative entry to this system. We held trainings on the use of the UBID system. We also have added features where users now can populate the text box with previous year's narrative and make necessary edits. Users now can export their entry or submission to a word document for future record keeping. The system checks for the character length of each section to assure that length limits were met.

Announcement Flyers/Newsletters
To increase public awareness about MCH program activities, we additionally requested Office of Health Disparities Reduction (formerly known as the Center for Multicultural Health) staff to add the public comment announcement in their on-line newsletter, Connections. The UDOH news media person was contacted to put the announcement on UDOH main public website. We prepared a public comment announcement flyer to spread the news. This notification was posted on the Utah Department of Health (UDOH) employee intranet, DOHnet, which is available to approximately 1,300 employees in the Department throughout the state. Flyers requesting input were posted throughout the UDOH Building.

Other Outreach Methods
UDOH staff and other agency partners were informed and briefed about the Block Grant Application and public comment process during regular bureau, data, and taskforce meetings.

All input received from emails and web application was compiled in a document and shared with the core program staff responsible for specific National and State Performance Measures to consider for incorporation in the final 2014 Annual Plan. Comments were incorporated into the plan as appropriate.

In addition, in June, 2013, MCH Bureau sponsored a meeting of key stakeholders, including local health department staff, community health center, UDOH staff from programs that relate to mothers and children, and community based organizations, such as Planned Parenthood of Utah, and March of Dimes. We reviewed the Performance Measures that we did not attain in FY2012 and asked for input on strategies we could use to advance the measure in the right direction. The discussion was led by two facilitators for two MCH categories: 1) mothers and infants; and 2) children and youth. Each facilitator discussed the related performance measures and solicited the strategies from stakeholders that would assist the state in moving the measure in the right direction. The two facilitators also discussed the performance measures that we did attain to show how the current strategies can keep those measures moving in the right direction even further. The comments and suggestions generated at that meeting were shared with staff responsible for the measures to incorporate as appropriate into the Annual Plan for FY2014.

We have received a lot of positive feedback on the meetings this year and feel good about the level of feedback and engagement of stakeholders.

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Title V Needs Assessment was guided by the Department of Health's vision, "Utah is a place where all people can enjoy the best health possible, where all can live, grow and prosper in clean and safe communities". The Utah Title V vision is that all women, mothers, children, youth, including those with special needs, and families in Utah are healthy. These visions guided the framework for the FY2011 MCH needs assessment process.

Prioritization Process

The original priority list consisted of 26 issues. Program managers held separate work group meetings with their staff to select their priorities and submitted them to the leadership team. Through discussion and review of impact, numbers affected, appropriate purview of the Department of Health, measurability and availability of data, issue is not covered in National Performance Measures, our ability to influence and success in addressing the issue, the Needs Assessment Leadership Team selected 10 measures.

Utah's ten priorities for FY11- 15:

SPM 1: Increase the percent of women of reproductive age (18-44 years) who report that they take a multivitamin pill or supplement containing at least 400mcg of folic acid daily.

SPM 2: Reduce the percentage of primary Cesarean Section deliveries among low-risk women giving birth for the first time.

SPM 3: Reduce the percentage of live births born before 37 completed weeks' gestation.

SPM 4: Increase the percentage of Medicaid eligible children (1-5) receiving any dental service.

SPM 5: Increase the percentage of primary care providers/medical homes that conduct routine age-specific developmental screenings in their practice.

SPM 6: Decrease the percentage of students who smoked cigarettes; smoked cigars, cigarillos, or little cigars; or used chewing tobacco, snuff, or dip on at least 1 day during the last 30 days.

SPM 7: Decrease the percent of adolescents who feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the last 12 months.

SPM 8: Increase the percentage of students who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes per day on 5 or more of the past 7 days.

SPM 9: Increase the percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.

SPM 10: Increase the percent of children (birth - 17) eligible for Medicaid DM who are also eligible for SSI.

/2012/ Needs Assessment Summary

a. Utah's population is more diverse than originally thought at the time of the FY2011 Grant submission. Every population group grew during 2000 - 2010. For example the Hispanic population grew almost 78%, Black population grew almost 66%, the Native Hawaiian/Pacific Islander population grew 62%, Asian by 49%, and Native American/Alaskan Native population grew by almost 11%.

b. During the 2011 Legislative Session, the Department lost additional funding, though not at the drastic levels experienced in the previous years. The economy seems to be picking up slowly and revenue projections are positive. Title V programs did not sustain additional state cuts, allowing us to stabilize our CSHCN clinics. We are currently cutting back on some services, such as pediatric neurology in the outlying areas.

c. We have continued to review data and discuss ways to address the State Performance Measures. We are engaged in a process with local health department leadership to review the Block Grant, its requirements, funding allocations, and services provided. The group is the result of legislation that went into effect in July 2010 that mandates review of all federal grants to determine if there is a role for local health departments and if so, to define that role and then to provide funding to support the local health departments' work. We are currently in the middle stage of the review, having covered the grant requirements, work to produce the grant, staff paid by the grant and their responsibilities. We have reviewed contracts and reporting requirements. Next steps include a further review of the role of LHDs and the budget, leading to recommendations to forward to the Governance Committee.
d. Several actions that we have taken to operationalize the plans: we have a position that is dedicated to training on the Ages and Stages tool for child care providers. As we make inroads there, we want to expand training and use of the tool to health care providers and others. To better address the health of school age children, we created a position for a school health consultant to address health issues such as medication administration in schools, school nursing, etc. We believe that this position is critical in identifying and addressing the health of the school age population, especially the few school nurses we have.

In the FY2011 grant federal review, comment was made about why certain measures were dropped and others added. The youth suicide, measure was questioned and is covered in 2 ways: the National PM and the State PM of youth feeling sad or hopeless. We were unsure why the question was asked as we believe it is covered, though not identified as a state priority. We clearly stated that if an issue was included in covered the national PM, we would not prioritize it since we are required to do so.

From the FY2011 Grant Application:
"The Leadership Team decided not to include any issue that was addressed in a National Performance Measure so that we could specifically focus on other areas of need." Additional comments on the changes in state Performance Measures - Some in the 2006 Needs Assessment were dropped because of higher priorities, we had worked on an issue for a number of years and difficulty in measuring the Performance Measure. We decided to put emphasis on late preterm births, most of which are preventable, health concerns for children and adolescents, and coverage and services for children with special health care needs. As we continue the work to address the ten priorities, we are engaging our key partners, such as local health departments, advocacy organizations, existing advisory committees, and parents. //2012//

/2013/ Needs Assessment Summary
a. Utah's economic picture is improving - decreased unemployment rates and increased insured children. Utah had a surplus for the budget, but the bulk of the money for public health went to Medicaid growth.

b. We have no changes in our priorities and do not plan any until the next needs assessment. We are engaging the local health departments in planning for the 2013 application as well as other partners. The Grant has undergone close scrutiny by the Governance Committee which delegated a detailed review to 6 local staff and 6 state staff. The committee reviewed the guidance requirements, grant and needs assessment documents, budget allocations, LHD contracts, etc. The workgroup consensus was the Department was meeting the grant requirements and that the funding allocation did not need to change unless funding levels changed. However, the Governance Committee questions the current allocation of funding to LHDs suggesting that funding for a state position could go to LHDs for direct services. The challenge is explaining the pyramid of services and expectation that states invest in infrastructure and population based services. We believe that state staff has a greater impact on the "system" compared to the impact of LHD direct services. We will continue to work with the Governance Committee so that they can better understand the grant and its requirements.

c. This year we directly involved the local health departments and other partners in the grant

planning. We invited interested local staff to participate.

d. Each year we review state data, trends and accomplishments to identify areas needing improvement, especially in areas we are not progressing in the right direction. We adjust program activities to move towards better impact. For the FY2013 grant, we focused specifically on the seven Performance Measures that we did not achieve the previous year to develop better or different strategies. This year we are focusing a great deal of energy on "healthy babies" which we have defined as preconception to age 5 so that we can focus on the health of the woman before pregnancy and her child's health through early childhood as a critical period of development. The effort is called "Healthy Utah Babies" or HUB. THe prematurity prevention efforts will be included in this work. //2013//

/2014/ We have no changes from previous year. We continue our work on the "Healthy Utah Babies" initiative and are in the process of working with key partners to form a Utah Women and Newborn Quality Collaborative to address pregnancy outcomes for mothers and babies. We will co-sponsor a MOD Prematurity Symposium in fall of 2013. //2014//
An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Utah is largely a rural and frontier state, with the majority of the state's population residing along the Wasatch Front, a 75-mile strip running from Ogden (north) to Provo (south) with Salt Lake City, the state's Capital, in between. The Wasatch Front comprises only 4% of the state's land mass, but 75% of the state's population. The rest of the population resides in the remaining 96% of the state's landmass comprised of 12 rural counties of more than six, but less than 100 persons per square mile and 13 frontier counties of less than six persons per square mile. Utah's population density is 33.95 persons per square mile compared to 88.08 persons per square mile nationally, Utah ranks 41st for its population density.

Population Demographics
In 2010 Utah's population was 2,763,885, an increase of 23.8% from 2000, compared to the U.S. rate of 9.7%. Utah ranked third among states for its population growth rate. While Utah is predominately white and non-Hispanic (80.3%), it is becoming more diverse with 13% report being Hispanic, 2% of Asian descent, 1.2% American Indian or Alaskan Native, 1.0% Black and 0.9% Native Hawaiian or Pacific Islander and 2.7% reporting more than two races. The population of every racial and ethnic group grew at a higher rate than the overall state population. The state's ethnic and racial diversity is increasing, although its minority share of 19.6% is much lower than the nation at 36.3%. ***/2014/Utah's population growth of 1.5% ranks the state fifth compared to the nation at 0.7%.//2014//***

Refugee populations in Utah are growing, along with the Hispanic populations, with resultant increasing need for language translation services and greater cultural awareness. The changing demographics in Utah challenge the health care system's ability to adequately address the needs of diverse populations. The Department actively participates in a Refugee Health Advisory Board to address critical health issues for refugee populations.

/2013/Utah typically grows faster than the nation after recessions, a pattern noted with the current recovery. National employment grew 0.9% in 2011 compared to 2.3% for Utah with an unemployment rate ranking 16th at 7.4% compared to 8.0% in 2010. Economic growth is expected to accelerate during 2012. Employment is forecast to increase 2.7% for the year. Housing permits are forecast to move up slightly from historic lows.//2013//

Cultural Diversity
Culture is more than country of origin or color of skin; it incorporates numerous different cultural factors, such as religion, language, poverty, education, family structure, etc. As Utah's population becomes more diverse, we see more populations of people who speak languages that are less well known to many Americans, populations with many varied cultural beliefs about health, health care, health practices, etc. These differences present challenges in delivering health care services and education about the health care system.

A significant culture in Utah is the Mormon population because Utah's predominant religion (LDS) counsels against the use of tobacco and alcohol which consequently results in a lower incidence of diseases associated with abuse of these substances, such as liver disease, alcoholism, and lung cancer. Utahns pride themselves on family values and support many efforts to improve maternal and child health. Utah is one of the most religiously homogeneous states in the Union. Between 41% and 60% of Utahns are reported to be members of The Church of Jesus Christ of Latter-day Saints (LDS or Mormon) which greatly influences Utah culture and daily life.

The overall political environment is conservative with a fairly large group of individuals who hold anti-government philosophies that at times make it difficult to obtain state funding for state agency programs. Of particular concern is meeting health care needs of the Hispanic population due to the increasing number of residents without documentation. These families are more difficult to

reach due to language barriers; cultural beliefs about preventive health care; transportation constraints; and ineligibility for many government programs. Prenatal care for women without documentation is a problem since they are not eligible for public assistance, even though their newborns will be citizens and eligible for benefits. In 2009, the then Reproductive Health Program (now Maternal and Infant Health) participated in a qualitative data project of the Center for Multi-cultural Health to obtain data from Hispanic women to better understand their health issues. The Center is finishing a report on a number of health issues of various sub-populations in the state. /2012/State legislators have been committed to ensuring that illegal immigrants are banned from public services. Most public health services for children have been exempted.//2012//

/2012/Legislation passed in 2011 requires that an adult applying for public benefits must provide proof of legal status before receiving services. In addition, legislation was passed that created a guest worker program, which probably is in conflict with federal policy, but was proposed as a state answer to a federal issue. Governor Herbert presented the state plan to national policy makers as a possible solution to immigration issues. //2012// /2013/The law excludes services to children and youth.//2013//

Utah Title V programs have worked to promote increasing awareness of the Department of Justice regulation announced in 1999 that assures families that enrolling in Medicaid or the Children's Health Insurance Program will not affect immigration status. Many families remain skeptical about applying for any government programs for fear they will be reported to the U.S. Citizenship and Immigration Services (CIS) or that their immigration status will be affected. The 2006 and 2007 Utah Legislators debated bills restricting undocumented immigrants from obtaining a driver's license, in-state college tuition, and state funded programs and so on. The bills on driver's license, state funded programs and in-state college tuition all passed. The legislative sentiment is not supportive of undocumented workers in the state. CIS has conducted a number of raids of businesses looking for undocumented workers with the result of families being torn apart, leaving some children without any parent to care for them.

Household Size

For many years Utahns have had larger households compared to the nation. Latest data (2008) indicate that Utah's household size was 3.15 people compared to the national average of 2.62. Utah's average family size was 3.67 people compared to the national average of 3.22. /2013/Utah's household size is smaller than previously at 3.1 but still ranked as highest in the country.//2013// ***/2014/In 2011 Utah's household size was the highest in the nation at 3.13 persons.//2014//*** The percent of Utah family households with children are 21.5% higher than the nation, 39.1% vs. 30.7%. Households comprised of single mothers with children are lower in Utah than the nation, 5.5% compared to 7.4%. Utah ranks 1st highest for child dependency ratio at 51.8 vs. 37.7 nationally. ***/2014/now 53.0 vs. 38.2 nationally.//2014// /2014/ Utah's ranking by the Kids Count data is 2nd for family and community due to the relatively low proportion of Utah childdren living in single-parent families (21%) and low percent of Utah children who live in families where the household head lacks a high school diploma (9%).//2014//***

Utah's Economy

The current economic situation in Utah is improving. Fortunately Utah has not been impacted by the recession as significantly as other states, but the unemployment rates reached an all time high during 2010. The rate is declining slowly as are the demands for services such as Medicaid, CHIP, food stamps and WIC. /2012/Utah's economy has improved somewhat, but not to the level before the recession. For Utah the employment rate grew 3.2% compared to the U.S. growth of.4% in 2012. While employment increased during 2012, Utah's unemployment rate also improved to 5.7%, lower than the 2011 rate. //2012// ***/2014/According to the Kids Count data, more Utah kids live in poverty, more parents lack secure employment and more teens can't find jobs than in the previous year. The percentage of families that struggle with a high housing cost burden increased.//2014//***

Utah's median household income was somewhat higher than that of the U.S. However, Utah's

house-holds are also larger resulting in a significantly lower per capita income in Utah than in the U.S. overall. Based on the 2008 American Community Survey Summary, Utah's median household income of $65,226 was slightly higher than the U.S. average of $63,366, ranking Utah 20th nationwide. /2013/The 2010 ACS reported median household income in Utah of $54,744, ranking Utah 14th highest in the nation. The national median household income was $50,046.//2013// ***/2014/Utah's median household income was $58,438 in 2011 ranking the state 11th.//2014//***

However, due to larger families in Utah, the per capita income ranked the state 45th lowest in the nation at $18,905. /2013/Utah's 2010 average per capita personal income was $32,473, a 1.8% change from 2009.//2013// ***/2014/Utah's per capita personal income of $33,509 ranked the state 47th among states.//2014//***

Utah's 2008 poverty rate (100% FPL) is well below the national average, 7.6% vs. 13.2% nationally. For children under age 18, almost 9% (8.8%) of Utah children live in poverty compared to 19.0% nationally. /2013/Utah's poverty rate has risen to 13.2% ranking Utah 17th lowest compared to national rate of 15.3% in 2010. Utah is 11th lowest for child poverty rate at 15.7%, below the nation at 21.6%.//2013// ***/2014/According to recent Kids Count data, Utah ranks 11th for economic well-being due to the fact that 16% of Utah children live in poverty (compared to 23% nationally) and 25% have parents who lack secure employment. While Utah's proportion of children living in poverty is well below the national figures, Between 2007 and 2011, the proportion has grown from 11% to 16%. The number of children whose parents lack full-time jobs was nearly 20%higher than it was five years ago.//2014//***

Education

Based on the 2008 American Community Survey, Utah had a significantly higher percent of its population with a high school diploma at 90.6% vs. 85% nationally among individuals 25 years and older. /2013/Utah ranked 7th at 90.6%//2013// Utah's population is similar to the nation for population with a bachelor's or higher degree (29.3% in Utah compared to 27.7% of the U.S.). Even though the proportion of Bachelor's degree and higher education achievement was comparable, Utah has a higher percent of individuals with some college but no degree at 27.4% compared to 21.3% nationally. ***/2014/ Utah ranked No. 30 in education according to the most recent Kids Count Data due to the fact that 60% of Utah children do not attend preschool, 67% of fourth-graders are not proficient in reading, and 65% of eighth-graders are not proficient in math. Utah's educational attainment ranks the state at 14th with 90.3% of persons 25+ with a high school degree. In 2011 elementary school class size varied between 22 -- 27 students per teacher and in high school the ratio was 30:1. Utah legislators are not supportive of public preschool programs, resulting in the low proportion of children attending preschool. //2014//***

The high school dropout rate in Utah is lower than the U.S. at 3.1% of youth aged 16 to 19 years vs. 4.4% nationally for grades 9 through 12. Data from the 2008 survey indicate that Utah ranks 7th in the country for high school graduation at 90.4% compared to the national rate of 84.1%. In 2008 Utah ranked 17th among states for Baccalaureate degrees at 29.1% and 24th for advanced degrees at 9.4% compared to 10.2% nationally.

The National Center for Education Statistics identified Utah with the lowest funding per elementary and secondary student during 2005 to 2006 at $5,964 per student compared to the national average $9,963. Fortunately, the 2007 Utah Legislature approved an increase in teachers' salaries. However the student to teacher ratio is 23.7 students per teacher compared to the national ratio of 15.5 students per teacher. Utah classrooms in general have at least 10 more students per teacher than in classrooms across the nation. ***/2014/National average for educational expenditure per student was $11,665 compared to Utah's ranking as the lowest at $7,217.//2014//***

/2013/In 2010 more than 570,000 students were enrolled in public education, an increase of 2.3%

from 2009. Students are becoming increasingly diverse and score respectably on national tests compared with their peers in other states. In FY2009, Utah's public education expenditure compared to total personal income was 4.2%, ranking Utah 34th of states. Utah ranks 18th for individuals with a Bachelor's degree at 29.3%. Student enrollment continues to grow at Utah colleges and universities. In 2010, enrollment grew 6.2%. Enrollment in higher education is projected to increase in the next decade. //2013// ***/2014/More than 600,200 students were enrolled in public schools in 2012.//2014//***

Health Status of Utah Mothers and Children
/2014/Life expectancy in Utah is ranked 3rd longest in the nation at 78.7 years. In Utah, life expectancy at birth for males increased from 72.4 years in 1980 to 78.1 years in 2010, and for females from 78.6 to 82.2 years. In comparison, life expectancy at birth in the U.S. rose from 70.0 to 75.7 years for males, and 77.4 to 80.8 years for females. Utah's ranking for health of its children as cited in the most recent Kids Count data is 14th, a drop from the previous year of 11th. Utah's birth rate in 2011 was 18.2 per 1,000, compared to a U.S. rate of 12.7 per 1,000. Utah's general fertility rate was 83.6 per 1,000, compared to the U.S. rate of 63.2 per 1,000. Utah's mothers generally practice healthy behaviors which are reflected in pregnancy outcomes. Utah has already met the Healthy People 2020 goals related to weight before pregnancy, folic acid consumption, smoking and alcohol consumption prior to pregnancy, teen pregnancy, low birth weight, preterm birth, cesarean sections, and infant mortality. Two areas where Utah has not met Healthy People objectives are prenatal care and maternal mortality. While prenatal care rates are improving, maternal mortality is on the rise and is of concern to the State.//2014//

The median age of Utah's population is 29.5 years, ranking Utah as the youngest in the nation. Utahns are generally healthy as noted in the state life expectancy ranking. Since we have only a small population of individuals in the state who smoke, drink alcohol, use illicit drugs, the majority of Utahns don't suffer from the results of these behaviors. Obesity is probably one of our worst contributors to chronic disease, rather than due to smoking or alcoholism.

Health of women of childbearing ages is generally good, although, like other states, we are seeing an increase in obesity rates, diabetes and heart disease in the entire population.

Utah ranked first for births among women between the ages of 15 - 50 years for a birth rate of 20.16 per 1000 population in 2008 compared to 14.3 per 1000 nationally (2007). /2013/Utah's 2010 birth rate fell to 18.3, the lowest in 20 years. Utah continues to have the highest general fertility rate at 87.1 (2009) compared to US rate of 66.7 (2009).//2013// Utah's regular fertility rate has dropped to 36.6.

Utah continues to have the youngest population in the nation with a median age of 28.7 in 2008 compared to 36.8 nationally. /2013/Utah continues as the youngest state with a median age of 29.2, compared to the national at 37.2.//2013//

Utah's child population is relatively healthy when compared to national data as noted in the 2007 Survey of Children's Health. Over 90% of Utah children are reported to have excellent or very good overall health status compared to the national rate of 84.4%; 76.2% of children are reported to have excellent or very good oral health compared to the national rate of 70.7%. Utah has a lower percent of children with overweight BMI (23.1%) compared to that national rate of 31.6%, and a higher percent of children who exercised at least 4-6 days per week (44.3%) compared to the national rate of 34.4%. Utah scored lower than the nation in children having preventive medical visits (80.2% vs. 88.5% nationally); however, Utah scored slightly higher than the nation in the percent of children who received preventive dental visits (79.1% vs. 78.4%).

/2014/Utah children's health overall is better than children nationally. According to the recently released Kid Count data, Utah ranked 14th for health with 7% of babies born low birth weight, and 11% of Utah children lacking health insurance. In the most recent data

from the National Survey of Children's Health 2011/2012, Utah children fare better than their national counterparts in all but 7 areas out of 28 total. The areas that Utah children do not do as well as their national peers are: missed school days, uninsured children, lacking consistent coverage, receiving a preventive medical or dental visit, developmental assessment screening, receipt of mental health services in children with problems, and fewer children whose families sing or tell stories to their children.//2014//

/2012/The Commonwealth Fund's State Scorecard report for 2009 ranked Utah 23rd among states on overall child health status. In addition, the report indicates that of 21 indicators, Utah had 3 in the "top 5", 7 in the first quartile, 9 in the 2nd quartile, 2 each in the third and fourth quartiles, and one in the "bottom 5" among all states. The report showed that Utah's scores for certain indicators are excellent, such as Utah children having a medical home (14th), children aged 2-17 needing mental health treatment/counseling who received mental health care (18th), hospital admissions for asthma per 100,000 children ages 2--17 (8th), infant mortality (4th), young children (ages 4 months--5 years) at moderate/high risk for developmental or behavioral delays (8th), children ages 10-17 who are overweight or obese (1st), high school students who currently smoke cigarettes (1st), and high school students not meeting recommended physical activity level (7th). On the negative side, the state's ranking for other indicators is not as good as it should be: children with insurance (36th), children receiving preventive medical visit (46th), children with preventive dental visit (25th), children with oral health problems (33rd), and parents reporting that they did not receive needed family support services (51st). Fortunately, even with the poor rankings, Utah is ranked 5th for potential to lead healthy lives. Not to dismiss the need to improve in areas of health systems and indicators for children, we have a high hurdle to jump to ensure that Utah children continue to have a high potential to lead healthy lives.//2012//

/2013/The 2011 America's Health Report ranked Utah healthy in several areas ranking in the top 3 in 8 of 22 measures. Utah was 1st for cancer deaths and prevalence of smoking; 2nd for binge drinking, obesity and preventable hospitalizations; 3rd for adult diabetes, infant mortality and cardiovascular deaths. Utah ranks 5th in overall patient quality in hospital services. According to a CMS Hospital Compare report Utah has high patient satisfaction and performs better in areas such as heart attack, heart failure, pneumonia and surgical care. Survival rates are higher and percentage of patients being readmitted to the hospital is down.//2013// ***/2014/The America's Health Rankings Report ranked Utah as the 7th healthiest state in the nation. Among the core measures, Utah was first for adult smoking, diabetes, and cancer deaths, second for sedentary lifestyle, fourth for infant mortality, and eighth for children living in poverty. Among the supplemental measures, Utah ranked first for youth smoking, third for youth obesity, and 15th for teen births.//2014//***

Insurance Coverage
Based on the Utah 2008 Health Access Survey (UHAS), 11.9% of Utah's population reported no health insurance, a steady increase from previous years. The proportion of uninsured has increased in the maternal and child populations as well. In 2008, 8.4% of children under age 18 were uninsured compared to 7.3% in 2003. Of females aged 18- 49, 14.3% reported no health insurance in 2008 compared to 11.3% in 2003. More than a third (36.5%) of the Hispanic population reported no insurance in the 2008 UHAS. The steadily climbing rates of uninsured individuals in the state especially children and women of childbearing ages, is very concerning.

/2012/The Department released information on the uninsured in June 2011. The percent of uninsured Utahns showed little change from the previous year with 301,700 (10.6%) of the population lacking health insurance. The data represent a slight improvement from 2009 when 314,300 (11.2%) of the population, had no coverage. The change from 2009 to 2010 was not statistically significant. The uninsured rate of children eligible for the Children's Health Insurance Program (age birth-18 with parents' income up to 200% FPL) remained relatively steady at 12.3% compared to 16.3% in 2008 when the program was permanently opened. Of adults aged 19-26, 28.6% were uninsured, the highest of any age group. Obviously women of childbearing age are represented in this group.//2012//

/2013/The percentage of uninsured children up to age 18 currently is estimated to be 7.9% and for adults, the uninsured percentage is 13.4% according to data released in August 2012. Differences in methodology may account for some of the differences compared to previous years.//2013// ***/2014/Using new methodology, the percentage of uninsured children was 8.1%, an increase from 7.9%. For adults, the uninsured rate was 16.0%. However, according to the Kids Count data recently released, 16% of Utah children have no health insurance. //2014//***

In 2005 Governor Huntsman sponsored a state summit to discuss issues related to a state plan to address the increasing rates of uninsured. The Governor and the state legislature are leading an effort to develop a health care reform package to address the growing population of uninsured.

/2013/In 2011 Governor Herbert hosted the "Health Innovation Summit" with stakeholders and policy makers to map out principles for health system reform in Utah and highlight two major achievements of Utah's health system reform -- the Utah Health Exchange and the new blueprint for a modernized Medicaid program. These reforms are still under development, but the Governor expects them to contribute significantly to improved health systems. ***/2014/The Governor sponsored another health summit in the fall 2012 which focused on business approaches to health care. The state has been developing plans for health care reform before the ACA was passed. Utah has a small health insurance exchange, "Avenue H", which Secretary Sebelius has approved, in part, as meeting the requirements for state health care exchanges.//2014//***

Utah's Public Health System
Utah's public health system consists of 13 autonomous health departments, the State Department of Health and 12 local health departments. Half of the 12 local health departments are multi-county districts covering large geographic areas. Many districts include both rural and frontier areas within their service region. Many local health departments have been gradually moving away from direct services, recognizing that they do not have the capacity to provide primary care in their communities. They instead have shifted focus to the core public health services.

The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

The Department strives to improve the lives of all Utahns. We work with our partners to create healthy and safe communities and eliminate health disparities as part of a comprehensive public health system. We use data-driven, evidence-based interventions to promote healthy lifestyles and behaviors; detect and prevent injury and disease; and improve access to quality health care for all people of Utah, including the state's most vulnerable populations. We monitor the health of the population by collecting, analyzing, and sharing data.

The Division of Family Health and Preparedness houses the State Title V programs. The mission of the Division is to assure care for many of Utah's most vulnerable citizens. The division accomplishes this through programs designed to provide direct services, and to be prepared to serve all populations that may suffer the adverse health impacts of a disaster, be it man-made or natural.

/2014/The Department has embarked on a 4-year strategic plan with 4 goals:
1.Healthiest People
The people of Utah will be the healthiest in the country.
2.Health in Health Reform
Health reform will be compassionate, humane, and cost-effective. The focus is on the health of all the people of Utah by increasing access to care, expanding use of evidence-

based prevention interventions, and improving quality.
3.Transform Medicaid... Utah Medicaid will be a respected innovator in employing health care delivery and payment reforms that improve the health of Medicaid clients and keep expenditure growth at a sustainable level.
4.A Great Organization...
The UDOH will be recognized as a leader in government and public health for its excellence in performance. The organization will continue to grow its ability to attract, retain, and value the best professionals and public servants.

The first goal of the UDOH Strategic Plan is a strategy for healthy births, called Healthy Utah Babies (HUB). This initiative covers the preconception period through pregnancy and after, to children up to age 5. HUB incorporates a life course perspective. The effort includes the UDOH ASTHO/MOD Challenge to reduce preterm births, promotion of preconception health, breastfeeding promotion, and universal developmental screening using evidence based tools. HUB has provided an opportunity to broaden collaboration with chronic disease programs and others,//2014//

Health Care Services
The geographic distribution of the state's population presents significant challenges for accessing health care services for those living in the rural and frontier areas as well as for delivery of health care services. In the rural and frontier areas, many residents are not able to readily access health care services due to long travel distances and lack of nearby hospital facilities and health care providers, especially specialists. Specialists are not available to rural/frontier residents except by traveling hundreds of miles. In addition, residents living in the rural/frontier areas may be reluctant, if not unwilling, to utilize certain services in their communities, such as family planning or mental health, because of concern for confidentiality and anonymity in seeking these services in a very small town.

Maternal and child health services, including services for children and youth with special health care needs, are provided in various settings: through medical homes/private providers; local health departments, community health centers which includes a clinic for the homeless and migrant health clinics, and a number of free clinics.

Each local health department determines which services they provide for mothers and children in their district. In the past we had required the local agencies to conduct an assessment of health care needs for mothers and children. The assessments were used by some districts in redefining their focus for services, while others were not much engaged in the process. We now ask the local health departments to identify two to three top health care needs for mothers and children, set goals, describe activities to reach the goals and track trends.

Local health departments struggle to provide services with funding allocations that don't increase making it hard for them to meet the cost of living increases for their staff. The changing economy is resulting in less flexibility with dollars than in the past. State staff is sensitive to the impact that state budget cuts have on local agencies as well, and often will preserve the allocation of federal contract dollars to local agencies by eliminating state level Competition for funding is becoming a matter of carefully balancing what exists with current need, consideration of how the dollars will have the most impact. State level needs, as well as local level needs, may be sacrificed during a time of economic downturn.

/2013/One of the difficulties faced by local health departments, especially those covering rural and frontier areas, is the small amount of local funding for public health. When you have few people living in large areas of the state, there are limited local funds to provide public services and it seems as though public health loses out in the funding distribution.//2013//

Services available through LHDs vary by district. For example, direct prenatal services are no longer available through LHDs, although two districts provide clinic space and support staff for

pregnant women served by University of Utah Health Sciences Center providers and Family Practice Residents. Family planning services are available through mid-level practitioners in only a few health district clinics. The shift away from direct services provided by LHDs reflects the changing public health system to focus more on core public health functions, including health promotion and prevention services.

/2012/In a 2010 survey of local health department nursing directors about services each provides, the range of services reported varied from 15-23 services out of 24 possible. Services provided by all twelve local health departments include: immunizations, injury prevention, Presumptive Eligibility, tobacco cessation during pregnancy and breastfeeding. The services with the fewest local health departments providing: mental health services for children and mothers (most local mental health agencies are in different agencies), and prenatal care reported by only three of the local agencies,//2012// ***/2014/ as part of the upcoming five-year needs assessment, we will survey local staff to identify services provided and review the changes. //2014//***

Community health centers throughout the state and the Wasatch Homeless Clinic in Salt Lake City provide primary care to underinsured and uninsured MCH populations. Utah now has eleven CHCs with six centers located in rural areas of the state. Utah Farm Worker clinic operates under Salt Lake Community Health Centers, Inc. at its clinic site Brigham City in Northern Utah. Many of Utah's Hispanic workers, especially along the Wasatch Front, are not engaged in farm work and therefore do not qualify for these services.

Access to low-cost maternal and child health care services provided by community health centers is problematic in rural areas of the state since they span such large geographic areas. Fortunately new community health centers have opened in the more rural areas of the state. The Association for Utah Community Health, the state's primary care association, works to promote development of new or expansions of existing community health centers in Utah. Free clinics have formed to help address the needs of the uninsured population. Other areas of the state where access to low-cost health care services is problematic include: Tooele County, especially the Wendover area; Wasatch and Summit Counties; Bear River Health District; TriCounty Health District; and portions of Central and Southeastern Utah Health Districts. ***/2014/Native Indian women and children in Southeastern Utah may have to travel to Tuba City, Arizona to a new facility, Blue Mountain Hospital, for services if Indian Health Services is to pay for their care.//2014//*** While the local health departments in all of these areas receive Title V funds, demand for services far outstrips the amount of funding available.

Medicaid and CHIP
Utah has been at the forefront of health care reform since before 2002 when the Department was approved for a waiver to establish the PCN. In 2002, then Secretary of Health and Human Services, Tommy Thompson, authorized Utah's Primary Care Network (PCN), which had been approved by the 2002 Utah Legislature. Approximately 25,000 adults with incomes between 100%-150% of FPL without insurance will be able to qualify and enroll for preventive health services under this plan. PCN will enable women who are enrolled in prenatal Medicaid to continue preventive health care coverage for primary preventive care, including family planning services if desired.

/2014/The Governor has yet to decide whether Utah will expand Medicaid. He has indicated that his decision will be annnounced some time this fall. //2014//

Medicaid has a waiver program for children who are technology dependent which covers nurse case management services as well as home care. This program is administered by Title V in the Bureau of Children with Special Health Care Needs. ***/2014/As of 2012, more than 11,000 enrollees were covered under PCN.//2014//***

Since 1995 through 2012, Medicaid participants living in Utah's urban counties had been required to enroll in a managed health plan. This requirement is the Choice of Health Care Delivery

Program, which is allowed under a federally approved freedom-of-choice waiver. Throughout this period of managed care, the Utah Department of Health's Medicaid agency contracted with several managed health plans to provide services to Medicaid participants, including children with special health care needs, in Utah's urban counties. Medicaid participants in all but three rural counties are enrolled in a Prepaid Mental Health Plan for behavioral health services.

The enrollment numbers for Medicaid have increased almost 13% from 12 months ago, and Utah's Primary Care Network enrollment has increased 22%. Interestingly, CHIP enrollment is down 10.2% from last year, perhaps reflecting a shift of eligible children from CHIP to Medicaid. //2012// The challenge for the Department is that there are few state dollars for services for mothers, children and adolescents, including those with special health care needs and their families. /2012/ The University of Utah, which contracts with CSHCN to provide physician coverage for the developmental clinics, is facing concerning budget constraints as well and this will likely result in a reduction of the number of itinerant clinics which CSHCN can provide.//2012// ***/2014/Current enrollment numbers for Medicaid, CHIP and PCN are down from previous years, perhaps reflecting a better economy in the state. Unemployment numbers are down indicating that more people have been able to find jobs. Medicaid reported that almost 6,000 women enrolled in prenatal Medicaid in 2012.//2014//***

/2014/Factors contributing to the growing percentage of uninsured children in Utah include: 1) limited outreach to families to enroll children in Medicaid or CHIP, reflecting only a 70% enrollment versus other states' enrollment of 95%. 2) Utah's policy to require children who are legal immigrants to wait five years to enroll in Medicaid or CHIP, 3) Utah policy that restricts the 12 continuous months of Medicaid when status changes. 3) Utah's income eligibility restrictions to lowest possible income. //2014//

/2013/Medicaid is converting its health plan products to an ACO model in 2013 with 5 health plans contracting with Medicaid. It will be interesting to track the benefits of such a system. With the Medicaid mandates of the ACA being ruled unconstitutional, it will be interesting to track Utah's approach because many legislators are opposed to putting more state funds into Medicaid.//2013//

/2014/ACOs went into effect January 1, 2013 for Medicaid participants along the Wasatch Front, an area that includes about 75% of the state's population. We will be interested in seeing the effect the ACO model has on health outcomes.//2014//

Medicaid income eligibility for pregnant women and children to age 6 is set at 133% FPL. For children 6 or older, the income eligibility is 100% FPL. Since the income eligibility level for Utah's Prenatal Medicaid program has not increased from the original 133% FPL in 1990, many women and their families, best categorized as working poor, are ineligible for health care coverage, making it difficult for them to access health care, especially prenatal and family planning services. Both the prenatal and the children's programs require an asset test for eligibility determination. The asset limit of $3000 (reduced in 2010 from $5000) prohibits many families that otherwise would qualify for the program from being eligible. Bills have been proposed in recent Legislative Sessions to remove the asset test without success. ***/2014/ With the ACA changes set to go into effect in 2014, the qualifying poverty level will be raised to 138% for pregnant women and the asset test will be discontinued.//2014//***

Utah CHIP Program began in 1999 with an income eligibility of 200% of the FPL for children from birth to 18 years. In the beginning years, the Program has suffered from budgetary limitations and has had to cap enrollment to stay within its budget. Since opening of the program through 2008, the state legislature had not appropriated enough funding for the program to maintain open enrollment. After inadequate increases for several years, in 2004, 2005, 2007, the 2008 State Legislature authorized additional funding for the CHIP Program and designated it as a state entitlement program. Obviously the legislators value the program as they are very reluctant to authorize "entitlement" programs. CHIP services include: well-child exams, immunizations, dental

care, mental health services, prescriptions, hearing and eye exams, provider visits, and hospital and emergency room care.

/2013/As of August 2011, more than 39,000 children were enrolled in CHIP, with approximately 41% living at less than 100%FPL; almost 38% between 101%-150%FPL with the remainder with incomes between 151% to 200%FPL.//2013// ***/2014/In December 2012 more than 35,000 children were enrolled in CHIP.//2014//***

Hospital Systems in Utah
Utah's hospital system is comprised largely of the Intermountain Healthcare hospitals. The University of Utah Hospital is a single facility providing tertiary care. Other hospitals, mainly the smaller ones, are owned by various hospital systems such as HCA (MountainStar), Iasis and LifePoint. We have a total of 54 hospitals in the state, with 42 being delivering hospitals, 2 being children's hospitals.

The hospital health care system for MCH populations is well developed in Utah, with several large Maternal-Fetal Medicine Centers, ten self-designated Level III NICUs, and two tertiary children's hospitals (Primary Children's Medical Center and Shriners Hospital).

We have reviewed data from all birthing hospitals to evaluate which hospitals meet the criteria for a tertiary center. We would like to promote the importance of have tertiary level maternal fetal medicine physicians (MFM) as part of the definition of a tertiary perinatal center in addition to the neonatologist. In order to have good outcomes, the care of the mother needs to be at a tertiary level. All but one of the perinatal centers has a University-affiliated faculty member assigned and are well recognized throughout the state and the Intermountain West as a consultation and referral center for obstetrical and pediatric providers. The centers work with hospitals within their referral areas to encourage consultation and referral as needed, depending on the condition of the mother, infant or child. /2012/ We held the first meeting of representatives of the ten hospitals that self designate as Level III neonatal intensive care centers. The discussion was lively and the outcome of the meeting was that a smaller group of representative of the NICUs will meet to develop guidelines for Level III NICUs.//2012// /2013/MCH continues meetings with hospital representatives to discuss issues related to designation and capacity of the NICUs in the state and review of outcomes.//2013// ***/2014/ MCH continues meeting with the NICU representatives. Upon release of the new "Levels of Neonatal Care" guidelines from the AAP, a draft of "Utah Guidelines for Neonatal Care Services" was developed and is under current review.//2014//***.

DFHP staff interfaces with faculty and staff from these centers through various efforts, including Perinatal Mortality Review, Child Fatality Review, Perinatal Taskforce, clinical services, joint projects, and other committee work and through the Neonatal Follow-up clinic that supports graduates from all of the NICUs. Through these efforts, the need and importance for consultation and referrals between levels of service are emphasized via reports of mortality review findings, or reports on specific topics, such as low birth weight.

Health Care Provider Shortages
Utah, not unlike other areas of the country, suffers from a shortage of certain types of health care providers in different geographic areas, including nurses, neonatologists, dentists, mental health professionals, etc. The HPSA maps in the Appendix illustrate areas of the state with shortages of various provider types. Provider shortages exist throughout the state. Utah's 2007 physician-to resident ratio was eighth lowest in the nation at 208 physicians per 100,000 resident population compared to a national rate of 271. The Health Professional Shortage Area (HPSA) maps detail areas of the state with provider shortages for medical, dental and mental health providers. Access to dentists in Utah is a major issue, particularly for Medicaid participants and for individuals living in rural/frontier areas of the state. The University of Utah Health Sciences Center is currently working on a proposal for a dental school; however, local dentists by and large do not support the efforts. Mental health providers, especially those specializing in children's mental health, are

limited, in part due to the mental health system in the state which is a Medicaid carve out serving primarily the chronically mentally ill, but not necessarily those with acute conditions. /2013/The University of Southern Nevada, a private dental school, in Salt Lake City, enrolled first year students in fall 2011. In April 2012, the University of Utah announced the opening its dental school in fall 2013.//2013//

/2014/The American Medical Association data indicate that Utah ranks last in the country for primary care physicians with only 58.4 active primary care physicians per 100,000 people. The national average is 79.4 primary care physicians per 100,000 people. The Utah Legislature passed legislation to increase the annual class of students admitted to the University of Utah medical school by 40 more students, bringing the annual class size to 122 students. The increase in class size does not guarantee an increase in primary care physicians, however, as they generally have lower incomes than other areas in medicine. //2014//

Urban areas also experience shortages of certain types of health care providers, such as nurses, pediatric neurology, genetics, developmental pediatrics and primary care providers who care for adults with special health care needs as they have transitioned from their pediatric providers.

Access to maternal and child health care varies depending on the geographic area of the state. According to Health Professional Shortage Area surveys some areas in Utah have high ratios of women of childbearing ages to providers, resulting in limited access to a reproductive health provider in their area. Women in rural communities may have to travel many miles to a provider's office and/or hospital. More than half of Utah's counties are without any obstetrician or gynecologist for the management of high-risk pregnancies. One rural county has no prenatal care or family planning provider of any kind and several counties reported as few as 1 provider to 10,000 women of childbearing age, creating a need to assure better access to consultation services for rural providers.

Even where prenatal care providers are more numerous, under-and uninsured women may be confronted with caps on the number of women an agency is able to accommodate including Presumptive Eligibility determination for prenatal Medicaid. However, gaps exist in some areas of the state due to specific geographic situations, such as Wendover, uniquely located in two states with different rules and regulations governing federal and state programs.

Presumptive eligibility for prenatal Medicaid had been problematic in the state for a number of years, especially in the urban areas with limited access sites. In 2001 Baby Your Baby by Phone was instituted enabling women to apply more easily than in person. Pregnant women ineligible for PE or Medicaid and unable to afford private care are referred to one of two University of Utah Health Sciences Center prenatal clinics located in local health departments or to a community health center located along the Wasatch Front offering sliding fee schedules.

/2013/As of July 1, 2012, Medicaid will oversee the Presumptive Eligibility/BYB process. A recent audit revealed a concern about administering the program through 3 different Divisions, with no apparent responsible Division. With retirement of one of the MCH staff who had overseen much of the program, it afforded us an opportunity to transition the oversight responsibilities to Medicaid. We will be able to use the Title V funds from this position in a more effective manner.//2013//

/2014/ In response to the audit findings, the Maternal and Infant Health Program transferred responsibility for the oversight of PE sites to Medicaid. The transition has gone smoothly, freeing up staff time for other MCH activities.//2014//

In 2008, the Department of Health eligibility workers were moved to the Department of Workforce Services to consolidate all eligibility workers. Though initially concerned that the move would impact customer service, it seems to be working /2012/ adequately for some populations.

However, special populations, such as children with disabilities or children in Utah foster care or kinship placements are having a difficulties accessing Medicaid for which they are eligible. The difficulty is because Workforce Service intake workers have a general knowledge of Medicaid eligibility, but they often are not knowledgeable about special population Medicaid options. This problem is more common outside the Wasatch Front. The Utah Family to Family Health Information Network gets numerous calls from families who are unable to access Medicaid. //2012//

The Child Health Evaluation and Care (CHEC) Program, Utah's Early and Periodic Screening, Diagnosis and Treatment Program, provides coverage for services for Medicaid covered children that are recommended by the American Academy of Pediatrics. The guidelines for the CHEC Program are very similar to the AAP recommendations. The Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) found that services and quality varied among small groups of pediatric practices that were engaged in quality improvement processes. These practices served children enrolled in Medicaid and children with private insurance. In 2006, Medicaid changed policy to allow reimbursement to pediatric providers for fluoride varnish applications for eligible children. The service has not been widespread to date, but some pediatric practices are considering providing the service. ***/2014/ A sticking point with providers is that the well child clinic visits paid by Medicaid are inclusive of developmental screenings, However, given the low provider reimbursement rates, there is concern about the proportion of pediatric providers doing formal developmental screenings.//2014//***

/2013/ Of great concern is the lack of funding for Medicaid dental services. Adults, other than pregnant women, are not able to get dental care coverage through Medicaid.//2013// ***/2014/ With the likelihood of State Legislators turning away from Medicaid expansion, Utah will continue to see its population of uninsured rise. //2014//***

CSHCN
Most specialty and sub-specialty pediatric providers are located along the Wasatch Front, including the state's tertiary pediatric care centers, University of Utah, Primary Children's Medical Center and Shriners Hospital for Children. The location of most pediatric specialists and sub-specialists in the most populous area of the state presents a problem for provider access for special needs children in rural Utah. In several counties of Utah, there are no pediatricians or sub-specialists, necessitating families to drive long distances to access care for their children. In most cases, there is only limited additional itinerant coverage from the private sector for this large geographic area. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers. /2012/St. George, in the southwestern part of Utah, is the most promising of the remote areas of the state to begin to build pediatric subspecialty infrastructure. Intermountain Healthcare, Utah's large health system, has opened a St. George based Women and Children's Health Center, serving the five county area. This area is also home for approximately 45 physicians who are both family practice and pediatricians. There is now one metabolic geneticist. Additionally, the Intermountain Medical Center has a Neonatal Intensive Care Unit.//2012//

CSHCN Services
The CSHCN Bureau provides direct clinical services to several thousand children and youth with special health care needs. Services are available at the main Salt Lake City office, as well as satellite offices in Ogden and Provo. In addition, itinerant clinics offered through the CSHCN Bureau to rural communities without specialty providers; and, specialty centers (mentioned above) and several tertiary centers for high risk perinatal and neonatal care. These centers of excellence provide centralized specialty and subspecialty services to pregnant women, infants and children with high-risk pregnancies, neonatal intensive care, and numerous disabling conditions, such as asthma, hemophilia, cystic fibrosis, diabetes, Down syndrome, cancer and orthopedic disorders. Although this allows for better coordination of care because there are fewer providers, it also presents a problem of service delivery to high-risk mothers and infants, and special needs children in rural Utah. CSHCN provides direct services in their Salt Lake City office

for three specific populations: follow-up of premature infants, developmentally delayed preschool aged children and developmental/behavioral disorder school aged children and youth and to children with complex orthopedic issues. Many of the children now seen in clinics are those with ASD.

/2013/The CSHCN Bureau Director and medical director worked with the largest private insurer in the state to gain reimbursement for ancillary services provided in CSHCH clinics with mixed success. They have agreed only to reimburse services provided in most rural locations. CSHCN completed its 3-year HRSA Autism System Development grant and is in its last year of CDC's "Learn the Signs Act Early" grant. CSHCN has worked with community partners and the public to revise the Autism State Plan and CSHCN continues to organize the multiagency Utah Autism Initiative Committee. CSHCN now has a designated autism coordinator. An Autism Treatment Account was established with $1M in state funds. ***/2014/Additional funding has also been received to fund ABA therapy from Zions Bank Corp and Intermountain Healthcare.//2014//*** The law includes three components: Medicaid waiver, the Autism Treatment Fund and a pilot with the Public Employees Health Plan, each of which will provide an array of treatment services, to include ABA therapy, for 2 year old up to age 6, diagnosed with ASD. Outcomes will be evaluated in two years which may determine the future of state funding.//2013//

Utah's Title V programs are working toward the six CSHCN core components of:
1) family and professional partnership at all levels of decision-making; 2) access to comprehensive evaluation and diagnosis; 3) adequate public and/or private financing of needed services; 4) early and continuous screening for children; 5) organization of community services so that families can use them easily; and 6) successful transition to all aspects of adult heath care, work and independence. Over the past 5 years, numerous successful public and private projects have expanded and improved the service system for Utah CYSHCN and families at both the state and community level. Despite significant changes and improvements in the system, gaps in services and needs remain as evidenced by data from surveys and reports from parents and providers.

Although components of Utah's system of care have greatly improved for families, the system itself has become increasingly complex, especially in the areas of funding, insurance coverage and the increasing number of Utah residents who are culturally or linguistically diverse. Utah has seen a series of funding cuts over the past 5 years, affecting health, educational and social services across the state. Though Utah has the highest birth rate in the nation and a rapidly growing population, there has been no appreciable increase in the availability of specialty pediatric services over the past several years. Families continue to face formidable barriers in accessing services and coordinating care for their CYSHCN. /2012/CSHCN traveling clinics have been affected by several years of funding cuts, and now are facing a 10% increase in contract costs for physicians. As a result, the frequency of CSHCN clinics has been reduced in many areas.//2012// ***/2014/Additional reductions are anticipated.//2014//***

Families continue to face formidable barriers in accessing services and coordinating care for their CYSHCN. /2012/To mitigate these problems for families, CSHCN works closely with the Family to Family Health Information Center and Utah Family Voices. The Bureau also has a small contract with the Utah's Parent Training and Information Center to help support information and referral for families of children with autism.//2012//

The CSHCN Bureau is addressing these issues through the many initiatives, some of which include the Medical Home Initiative and Medical Home Portal website, Telehealth, traveling multidisciplinary clinics, the Fostering Healthy Children Program, community based case management teams, Baby Watch/Early Intervention and collaboration with Utah Family Voices and the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) grant. These initiatives are described in greater detail elsewhere in this document. /2013/CSHCN collaborated with the Medicaid Infrastructure Grant to provide training on transition to adulthood to Medical Homes throughout Utah.//2013//

/2014/All CSHCN clinics have implemented a new electronic billing and health record system. Lay midwives are also being trained successfully to reduce the number of children lost to hearing screening by screening their own births. Training and equipment have been provided by CSHCN through other HRSA grants.//2014//

As the Title V block grant is reduced by establishment of categorical funding streams, we face additional financial obstacles particularly when the law requires the Department to provide certain services or personnel without funding, such as the State Dental Director, newborn hearing screening, and so on. While Utah is not suffering the degree of economic down turn that other states are experiencing, we are definitely feeling the impact of the projected decreases in revenues. The decrease in the Title V Block Grant over several years and the fact that the funding allocation has not kept up with inflation rates result in challenges for us to continue to provide the same level of services. Examples include loss of staff positions, loss of content areas, such as SIDS and school nurse consultation.

Addressing the Needs of a Diverse Population
Documenting disparities at times is difficult given small numbers of populations in which to draw significance. The Department has endeavored to include data on subpopulations in the state in an attempt to better quantify the issues faced by various groups of individuals. The 2004 Legislature appropriated funding for the Center for Multicultural Health, which was supplemented in later years. The Center is housed in the Division of Family Health and Preparedness and assists the Department of Health in identifying priorities and needs of specific key populations in the state, updating an Ethnic Health Report, assessing the adequacy of ethnic data from common public health data sources and recommending improvements, informing ethnic communities about the Center's efforts and activities, and developing guidelines for cultural effectiveness for UDOH programs. The Center plays an important role in bridging the needs of ethnic communities in Utah and the work of the Department of Health and its partners in addressing these needs. The Center works closely with Title V programs to identify ways in which we can work more closely together on MCH needs. /2012/In 2011 the Center was renamed as the Office of Health Disparities Reduction (OHD) in order to put more emphasis on disparities which may occur among populations not necessarily defined by race or ethnicity.//2012//

OHD has gathered information to publish "fact sheets" to outline key health issues for each specific minority population. This approach will highlight the significant health problems for each population rather than by disease or health problem. The three Bureaus in the Division have designated at least one staff member who oversees MCH and CSHCN efforts in regard to multicultural activities and materials. The OHD has provided cultural competence training for both state and local public health staff. OHD is in the process now of identifying key health issues of each of the sub-populations living in the state. The Center has developed "fact sheets" for each subpopulation that addresses key health needs so that the specific needs of a population are highlighted rather than approaching health issues for minority groups by disease categories. These fact sheets have better enabled staff to focus efforts on the key health needs of each specific subpopulation. ***/2014/ OHD established a Birth Outcomes group to look at adverse pregnancy outcomes. As a result of this group, four culturally and language appropriate videos titled "for Me, for Us" were developed to discuss healthy weight, access to health care, and healthy births. The videos targeted African Americans, Pacific Islanders, Hispanics, and the broader general population. The videos were made available on You Tube in English, Spanish, Tongan, and Samoan. //2014//***

In addition, the Department has a staff person designated as the Liaison to the Native American communities in the state, which is helpful to programs attempting to address the unique needs of the Native American populations.

The health care system in Utah is developing more cultural awareness, especially as the population of Utah changes. The results of a 2009 Department of Health qualitative study of

ethnic populations indicated that individuals of ethnic populations feel as though they were inadequately or poorly treated because of their ethnicity; they wanted health care providers of their own ethnicity or providers who could relate to them and their beliefs; they want health care providers to ask them what they need and not assume what they need; they had to wait long times while others who arrived later were seen earlier; they need access to interpreters and materials in own languages; they want acceptance of their beliefs about health and prevention (one doesn't go to doctor if not sick); and, they want providers to be sensitive to gender issues. The Department plans on conducting another qualitative survey of ethnic populations in the state to determine current priorities.

/2014/The Governor has not yet announced his decision about Medicaid expansion. A report released recently during the Medicaid Expansion Options Community Workgroup meeting provides information for Utah policy makers as they consider whether to expand the state's Medicaid program under the Affordable Care Act (ACA). The report, produced by Boston-based Public Consulting Group (PCG), does not make recommendations on how the state should proceed, but rather analyzes the costs and benefits associated with five potential expansion scenarios. The PCG report estimates over the next 10 years the mandatory changes will
• Increase Medicaid enrollment by 60,202 adults and children
• Increase Medicaid service and administration costs by $762 million (due to federal matching money, the state share of this increase will be $213 million)
• Generate an additional $20 million in state tax revenues
• Generate an additional $16 million in county tax revenues
• Generate $516 million statewide in economic impact, create 747 new jobs.

The remaining four scenarios modeled in the PCG report all assume the state will expand its Medicaid program. The PCG report estimates over the next 10 years the costs and benefits of the full expansion scenario (traditional Medicaid benefits for adults earning up to 138 percent of poverty) will be:
• 123,586 additional adults would enroll in Medicaid
• Medicaid service and administration costs will increase by $3.2 billion (due to federal matching money, the state share of this increase would be $260 million)
• State public assistance programs would save $156 million
• County public assistance programs would save $39 million
• Generate an additional $113 million in state tax revenues
• Generate an additional $90 million in county tax revenues
• Hospitals would save $814 million in uncompensated care
• Generate $2.9 billion statewide in economic impact, create 4,160 new jobs

The Governor will announce his decision about Medicaid expansion in the fall of 2013. The mindset of the state legislators usually is for less government, less state dollars going toward federal programs, etc. So, it will be interesting to see how the potential expansion will play out in Utah.//2014//
An attachment is included in this section. IIIA - Overview

B. Agency Capacity

Title V in Utah maintains a strong presence in the public health arena, at national, state and local levels. Title V programs have been held in high regard for many years. With the Department reorganization in 2009, we are positioned to better integrate and collaborate more internally as well as externally.

Programs in three bureaus serve mothers and children, but previously have worked independently of each other. The reorganization affords an opportunity to revisit the MCH programs, improve efficiency, move towards stronger leaders over programs and better understand what we all do to improve the health of mothers and children. The reorganization has

provided a fresh look at clinical programs in terms of services we provide, how we provide them. We have had an effective working relationship with local health departments. As always there is room for improvement at the state level, and we anticipate that over the next year, we will be able to bring together state program staff from three Bureaus that serve mothers and children to discuss ways that we can better communicate, understand what each program does and its impact.

Budget shortfalls have impacted both MCH and CSHCN programs. The Governor imposed a hiring freeze at least until July 1, 2010. As a result, we have 26 vacant positions. CSHCN programs have been impacted significantly with state cuts of $1 million due to its large portion of state funds. In 2009 $1 million was cut in the CSHCN budget, but restored for one year. In 2010, the funding was not restored, resulting in a shift of Title V funds, loss of staff, or discontinuation or reduction of clinic services. Some staff members have been reassigned to other work. /2013/Utah's economy has improved creating a budget surplus, however, we did not receive any replacement funds for those cut in CSHCN clinics.//2013// ***/2014/Hiring has proceeded, however, we are currently holding off filling vacant positions until we know what cuts will need to be made. Positions funded with short term federal funds are now classified as a temporary position. For long term funding, such as Title V, positions can be filled through the career service system.//2014//***

Title V staff continually identifies needs of underserved mothers and children to prioritize allocation of resources. Staff weighs factors limiting access or availability of services across the state in partnership with community organizations and interested others. Staff develops plans and interventions to support health needs. Division staff review and analyze MCH data and produce reports, fact sheets, abstracts and articles for publication. Several published peer review journal articles included Division staff as authors.

/2013/The Utah Department of Health signed the challenge agreement with ASTHO and the March of Dimes to reduce prematurity rates in the state. As part of UDOH's strategic plan, healthy babies is a priority, a tremendous opportunity to promote preconception health and life course for healthier mothers and babies. The work focuses on preconception up to a child's 5th birthday so we can promote health during a time of critical development. The Department's inclusion of MCH is a first and gives us a wonderful opportunity to get support for what we already are doing and for expansion of our work in this area. The action plan includes the following areas: 1) prevention of prematurity, 2) promotion of breastfeeding as a means to reduce maternal and childhood obesity, 3) preconception through media and print materials, and 4) promotion of universal developmental screening with evidence based tools. //2013//

/2014/In November 2012, the Utah Chapter of March of Dimes with its partners, including UDOH, sponsored a Prematurity Symposium to discuss the impact of prematurity and develop an action plan to address the problem. Four main prevention areas were identified: 1) Optimization of inter-pregnancy interval, 2) Early identification and treatment of high-risk pregnant women, 3) Increasing the use of progesterone supplementation during high risk for preterm birth pregnancies to reduce recurrent preterm births, and 4) Increasing single embryo transfers for in vitro fertilization to reduce selective multiple gestations and resultant preterm births. At this meeting, Dr. Jay Iams presented on the quality collaborative work being done in Ohio and a formal proposal was made to begin work on establishing an ongoing, statewide Perinatal Quality Collaborative in Utah. It has also been proposed that the NICU collaborative group be incorporated into the larger quality collaborative. A collaborative leadership committee was formed and work has begun to convene an inaugural meeting in July 2013. The name of the collaborative will be the Utah Women's and Newborn's Quality Collaborative (UWNQC).//2014//

Data capacity
Department data capacity is very strong and focused around the Center for Health Data (CHD) which serves as the central point for state health data. CHD includes the Office of Vital Records

and Statistics, the Office of Public Health Assessment (OPHA), the Office of Health Care Statistics, and the Office of Public Health Informatics. The Division has strong working relationships with the four CHD offices and is intricately involved in projects, such as the UNScHIE grant, and other Department data projects. CHARM (Child Health Advanced Record Management), housed in CSHCN, links newborn hearing screening with newborn blood screening, vital records birth and death certificates, BabyWatch/Early Intervention and immunizations. CHARM will enable providers to look up a child's records to determine immunization status, newborn screening results, etc. Eventually CHARM will be incorporated into the cHIE system to link multiple data sets. Division staff is part of the oversight committee for several grants awarded to the Office of Public Health Informatics. CHD oversees the legislatively mandated Health Data Committee which is responsible for publication of hospital performance data on various measures, such as Cesarean deliveries. The Office of Health Care Statistics is responsible for health plan surveys and reporting plan performance annually and inpatient, ambulatory, and emergency room data. The Center's website includes "MyHealthCare in Utah" which is designed to help consumers make informed decisions about their health care. /2013/CHARM will enable authenticated and approved providers to look up a child's records to determine immunization status, newborn screening results, etc. Within the next year, CHARM data will be available through the cHIE system and other access points to link multiple data sets and provide the most current and accurate information available. //2013// ***/2014/ Information from the Birth Defects Network and from the Neonatal Follow-up Program will also be linked within the next few months.//2014//***

The Division has built extensive capacity for data analysis through the Data Resources Program. The Program has staff assigned to each of the three populations served by Title V programs. The Department has also built data capacity by forming the Center for Health Data which includes Vital Records and Statistics, survey data collection capacity (BRFSS, YRBSS, etc.), development of an Internet-based query system for health data (http://ibis.health.utah.gov/) that provides access to more than 100 different indicators and access to data sets, such as birth and death files, BRFSS, PRAMS, YRBSS, hospital and emergency department data, population estimates, and Cancer Registry. The Center for Health Data provides access to large data sets for analysis by Department staff (and others outside the Department as appropriate), and works with programs in the Department to assist in data analysis as needed. Medicaid has developed a data warehouse for Medicaid data that is used by Title V to link with vital records data to track outcomes for Medicaid participants.

The Data Resources Program (DRP) includes staff assigned to MCH and CSHCN. The expanded capacity has greatly facilitated access to data, as well as data quality and use of data for program planning efforts. The DRP coordinates the MCH Epidemiology Network that includes staff from MCH, CSHCN and other Department programs to discuss data needs, projects and policy. In 2007, the Data Resources Program formed another working group, the MCH Bureau data group, to discuss data projects and ideas focused only on the MCH populations. Staff from the MCH programs participates in the meetings which provide a forum for setting priorities, developing concepts of a data study, and so on. They enable program staff to learn what the others are doing or would like to do and are able to contribute ideas to each other's projects. CSHCN joined this group which has led to increased awareness of available data and uses for data to encourage more active research efforts within CSHCN programs.

The Division also oversees the Birth Defects Registry and the Autism Registry. Both are collaborative efforts between the Utah Department of Health and the University of Utah School of Medicine. We still have not been able to access WIC data due in part to the system failure even though the system has undergone significant reprogramming and works well now. The Utah WIC program is part of a three state Consortium developing an entirely new system which is undergoing user acceptance testing during June, July and August. Once that system is installed and operational we should be able to access WIC data. ***/2014/The WIC information system, VISION, was rolled out fall of 2012 and is operating very well. Significant staff time and efforts went into the development, design, testing and rollout of the system. Local WIC***

clinic staff appreciates the new system's functionality and reliability. We hope to be able to obtain data from the new system in the next year or so.//2014//

Title V programs
The Department has many programs that address needs of women, mothers, children and adolescents including those with special health care needs, and families. Some are fully funded with Title V dollars, while others are partially funded or funded by other sources, such as state or other federal funds. The programs outlined below provide preventive and primary care services to pregnant women, mothers, infants, and children and youth including those with special health care needs.

Each program that addresses the health of mothers and children has a specific program plan that identifies goals, objectives and activities. The process of strategic planning for each program varies from program to program. The Maternal and Infant Health Program, (formerly the Reproductive Health Program) has developed a plan based on the National and State Performance Measures and the one state Outcome Measure. /2012/now 2 state outcome measures //2012// Each staff member is assigned responsibility for one or more measures. For other programs, each is assigned responsibility for the related National and State Performance Measures in their program plans. Additional goals and objectives are developed by each program as issues arise, such as the need for dental services for pregnant women is incorporated in the Oral Health Program plan. Generally each program holds annual staff retreats to review the previous year's accomplishments, strategies and needs. Based on these discussions, program managers amend program plans as needed. The annual report and application process provides an opportunity for each program to review its accomplishments and to amend their program plan as needed based on its achievement of the assigned measures.

Bureau of Child Development
The Bureau of Child Development is a newly formed Bureau and brings together programs for young children: child care licensing, early childhood systems, Baby Watch Early Intervention and the Office of Home Visiting. The Bureau's vision is to support parents in their efforts to ensure their child's healthy development. ***/2014/The state match required for the Head Start State Collaboration Office grant was eliminated in 2012 so we no longer administer the grant.//2014//***

The Baby Watch/Early Intervention Program provides early identification and developmental services for families of infants and toddlers aged birth to three. These services are provided through the coordinated effort of parents, community agencies, and a variety of professionals. Services are delivered in the child's natural environment, which can include the child's home, child care settings, and other community locations, including local early intervention centers. Baby Watch serves children birth to three years of age who meet or exceed the definition of a moderate developmental delay in one or more of the following areas: physical development; vision and hearing; feeding and dressing skills; social and emotional development; communication and language, and learning, problem solving, and play skills.

Services offered include: a full assessment of a child's current health and development status; service coordination among providers, programs and agencies; strategies to build on family concerns, priorities, & resources (CPR), and developmental services: occupational therapy, physical therapy, speech/ language therapy, etc.

The Child Care Licensing Program's vision is to support working parents by protecting the health and safety of children in regulated child care programs. This is accomplished by:
- Establishing and enforcing health and safety standards for child care programs.
- Training and supporting providers in meeting the established health and safety standards.
- Providing the public with accurate information about regulated child care.

The program is responsible for implementing and enforcing the administrative rules that govern child care facilities. There are several different types of center-based and home-based child care facilities, each with its own requirements. Licensors travel throughout the state inspecting child care facilities to ensure children are safe and healthy care. All providers, including owners and members of the governing body, directors, employees, providers of care, volunteers, anyone age 12 or older who lives in a home where care is provided, and anyone who has unsupervised contact with a child in a care center is required to have a background screening before licensure, and an annual background screening when the license is renewed. Complaints against providers are investigated and any rule violations found must be corrected in order for the facility to remain open. Staff provides trainings in licensing rules for the providers.

Early Childhood Utah
/2014/In September 2011, Governor Herbert designated the existing ECCS State Team in the Utah Department of Health (UDOH), Bureau of Child Development (BCD), to also function as the State Advisory Council on Early Care and Education. This combined team is known as Early Childhood Utah (ECU). ECU is comprised of four standing committees: Access to Health Care and Medical Homes, Early Care and Education, Mental Health Services, and Parenting Education and Family Support.

ECU is striving to ensure that all Utah children enter school healthy and ready to learn by improving the healthy physical, social, and emotional development during infancy and early childhood, eliminating disparities; and increasing access to needed early childhood services by coordination and collaboration at both the state and local level. ECU is working to ensure that all Utah children enter school healthy and ready to learn by:
•working with public and private partners to foster the development of cross sector service systems;
•identifying opportunities for, and barriers to, collaboration and coordination among early childhood programs and services;
•assessing and developing recommendations for improving quantity, quality, and participation in early childhood programs and services;
•assessing and developing recommendations for improving the capacity and effectiveness of professional development training and education for early childhood service providers;
•assessing and making recommendations for improved early childhood data collection and usage; and
•engaging in mutually agreed upon cross sector work projects designed to accomplish these purposes.

A major focus of ECU is the development of a multi-agency data sharing project which will facilitate data sharing and coordination among early childhood programs in Utah. The data system will allow for study of longitudinal outcomes so that we can examine which programs or combination of programs lead to the best long-term outcomes not only in early childhood but also as children transition to school and to employment. Currently, assessment of health and development is fragmented and siloed, making it difficult to completely understand families' needs in order to collaborate and coordinate needed services. Key data from multiple early childhood databases will be integrated into the state's longitudinal data system, resulting in a usable data source from early childhood through elementary, secondary, and post-secondary education and into the workforce. This system will enable agencies and programs to track long-term outcomes due to early childhood investments, and make better informed policy, program, and resource decisions.//2014//

The statewide developmental screening initiative works to promote developmental screening of children age birth through five years using the Ages & Stages Questionnaire (ASQ). Child Care Resource & Referral agency staff train early care and education providers to use the ASQ with children in their care and share screening results with parents. The program aims to help early care and education providers connect children and families to community resources for child

development.

/2014/Help Me Grow (HMG) is a resource and referral program that maintains an integrated child and family referral service. The Program uses the ASQ developmental screening tools with families by distributing ASQs to parents of all young children who enroll in HMG. HMG helps parents score the questionnaire and shares the results with the child's health care provider. HMG currently operates in Utah County and is in the process of expanding into Salt Lake County. In the coming year it will also pilot its first rural expansion into Carbon, Vernal and Duchesne Counties. The Bureau believes that HMG has the potential to be an umbrella service that could link multiple early childhood programs/services and integrate them with ongoing developmental screening with other services.

UDOH is collaborating with Help Me Grow Utah (HMG) to provide universal screening for young children. The HMG program helps to find services for children birth through 8 years age that are at risk for developmental or behavioral concerns. Using a comprehensive database of current community based services and resources, Care Coordinators are able to refer families to appropriate services. The Care Coordinators talk to families about options and help them maneuver through the maze of services and programs. Follow-up is done to ensure the families have been linked to services and to see if additional referrals are needed. The Care Coordinators also mail general information on child development or specific developmental issues to families. Families have the option to sign up to participate in a child developmental monitoring program using the ASQ.

HMG has the capability of reaching all children in a community through their health care provider and community outreach efforts. HMG enrolls families, assists parents in completing ASQ developmental screenings, and sends screening results to parents and (with parental permission) to the child's health care provider. For children whose screen indicates possible developmental concerns, a referral for a more comprehensive assessment is made. A benefit of having HMG as the conduit for developmental screening is the linkage it provides to health care providers. With parental consent, all screening and referral information is communicated to the provider, allowing a collaborated, comprehensive approach to treating the whole child.

Currently, three UDOH programs in the BCD contract with Help Me Grow. These programs are: Baby Watch Early Intervention (BWEI) and Parent Support Programs (PSP) which include ECU and the Office of Home Visiting (OHV).//2014//

The early childhood data integration project to facilitate data sharing and coordination among early childhood programs in Utah, in order to:
•Evaluate long term outcomes for children who participate in early childhood programs,
•Improve child outcomes and the quality of early childhood programs by promoting data-driven decision making,
•Answer key policy questions regarding early childhood programs and services,
•Evaluate data that is timely, relevant, accessible, and easy to use to answer policy questions and
•Facilitate the State's ability to participate in funding opportunities by collecting basic information on children, early childhood professionals, and early childhood programs

Using a combination of ECCS and SAC funding, key data from multiple early childhood databases will be integrated into the state's longitudinal data system being developed by the Utah Data Alliance, resulting in a usable source of data from early childhood through elementary, secondary, and post-secondary education and into the workforce. This will enable agencies and programs to track long-term outcomes from early childhood investments and make better informed policy and resource decisions,

Office of Home Visiting
The mission of the Office is to promote a coordinated service continuum of research-informed home visiting that supports healthy child development and ensures the safety of young children and family members by: developing state infrastructure to support home visiting; supporting a local continuum of services; providing training and technical assistance to local programs; securing sustainable funding; and, evaluating outcomes and quality of services
The Office of Home Visiting (OHV) acts as a support and resource center for entities interested in implementing an evidence-based or research-informed home visitation program. The OHV provides
•Support for home visiting programs with training and technical assistance
•Support for starting new evidence-based home visiting programs
•Augmentation and/or development of knowledge and linkages between home visiting programs and the related services systems at the state and community level identified as but not limited to:
oOther home visiting programs
oHealth care providers
oSubstance abuse providers
oMental health providers
oChild care, and
oParenting programs
•Identification of existing and new sources of funding for local home visiting programs
•Promotion of evidence-based home visiting as an effective way to prevent child abuse
•Evaluation of EBHV programs currently operating in Utah

OHV funds several home visiting programs in the state based on three evidenced-based models: Nurse Family Partnership, Parents as Teachers, and Healthy Families America.

CSHCN Bureau
The CSHCN Bureau oversees seven programs focused on improving the statewide system of care for CSHCN and their families. The Bureau provides services through local and itinerant clinics, care coordination for children seen in clinics and for target groups of children such as those in foster care and those dependent on technology living at home. The Bureau works closely with hospitals and health providers to ensure that all newborns receive hearing and blood screening. CSHCN staff works closely with medical homes/primary care providers to ensure care is coordinated. Families are billed for clinic services on a sliding scale based on Federal Poverty guidelines. Clinics are primarily funded by Title V, Medicaid, CHIP, state, and collections from private insurance. Newborn blood screening kit fees fully fund the Newborn Blood Screening program and partially fund newborn hearing screening.

The Bureau oversees Department efforts for the Autism Infrastructure Project in its third year of a HRSA ASD/DD system development grant which focuses on improved identification of cases and analysis of prevalence data. The Utah Newborn Screening Information Exchange project (UNSCHIE) will expand the Child Health Advanced Records Management (CHARM) project which allows sharing of health data among different data systems. CSHCN continues other major initiatives including the Utah Collaborative Medical Home; Transition for Youth and Young Adults programs; SSI outreach information and referral.

Utah Birth Defect Network (UBDN) is a population-based statewide program that provides surveillance, research, and prevention of birth defects. UBDN provides the basic infrastructure to monitor all pregnancies and infants with a birth defect in Utah. These data provide the necessary information to assess the prevalence of each phenotype, trends over time, and to serve as the case group for research. /2013/BDN successfully applied with the University of Utah (UofU) for a newborn critical congenital heart disease grant.//2013//

Developmental Consultative Services Program provides developmental evaluation, diagnosis, and referral to community resources for children up to age 8 who are at high risk of developmental delays or chronic disabling conditions. CSHCN clinicians coordinate services with

the Medical Home or primary care provider for recommended follow-up and referral to appropriate services and early intervention programs.

The program for family involvement, leadership and support provides information and support to families of children and youth with special health care needs and the professionals who serve them. The program in collaboration with Utah's Family to Family Health Information Center and Parent Training and Information Center provide individual consultations, workshops, publications and web-based educational materials. The program partners with various disability, advocacy and family organizations in the State in organizing events throughout the state in a conference format. Parent participation and perspective is added into all the programs and services delivered to children and their families. The MCH programs continue to be fortunate to have excellent family advocates who are known nationally as well as in the state promoting the needs of children and families. The Family Involvement Program collaborated with the University of Utah in the Children's' Healthcare Improvement Collaboration (CHIC) that is funded by a CHIPRA grant for a Medical Home Demonstration Project. Through this project the Utah Family Voices Director contract to coordinate Family Partner activities and training, provide information and resources to the Medical Home Coordinators and visit each of the sites to provide technical assistance and training on community based resources. There are 12 clinics involved in the project with three of them being a specialty practice. Through this project and Medical Home initiatives the UFV Director was able to spread statewide building capacity for comprehensive, family-centered, coordinated, culturally competent health care for children with special health care needs. The CHIC project has Medical Home teams that include a parent partner, a primary care provider, a medical home coordinator and office staff. The University of Utah's Department of Pediatrics also host a website, the Medical Home Portal www.medicalhomeportal.org, developed through collaboration with additional partners that contains information on diagnosis, special education, transition, family issues, coding, and resources for providers and families. The website is being adapted to include local services from other states and includes guest authors from other states. Additional CSHCN staff submits a quarterly article in the newsletter for the Utah Chapter of the American Academy of Pediatrics referred to as the Medical Home Corner, and provides on-going expansion of content and services to the Medical Home Portal. Many children, youths, and adults with special health care needs are Medicaid recipients and low provider reimbursement rates are a barrier to finding providers. Routine preventive dental care for children, youth and adults with special health care needs is especially difficult to access because many dentists are reluctant and/or not trained to treat individuals with disabilities. The CSHCN Transition Specialist, SSI Specialist, and Medical Home Care Coordinator addressed some of these issues through information, referral, and Transition to Adulthood training for Utah Medical Homes. CSHCN staff has been instrumental in developing transition modules on the Medical Home Portal website noted below. Additionally, several dental homes were provided training in dealing with the unique needs of children with autism spectrum disorders. The training was provided through a partnership with CSHCN staff and staff at the University of Utah's Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) with funding through a federal grant. www.medicalhomeportal.org.

Neonatal Follow-up Program tracks very low birth weight babies less than 1250 grams through their first 2-1/2 years. The program follows health and growth status, neurological function, learning and attention abilities, development, hearing and vision, behavior, language, school performance and social skills through periodic screenings. A summary report of the clinical findings is shared with the Medical Home or primary care provider and respective newborn ICU and research.

The Hearing and Speech Program serves as the coordinator and central registry for State mandated newborn hearing screening under Utah's Newborn Hearing Screening Act, 26-10-6, 1998 General Session, Title 26, amended by Chapter 162. The database serves as the Utah registry for permanent hearing loss. The program is responsible to assure all infants born in Utah are screened for hearing loss before 1 month of age; have a complete diagnosis before 3 months if they fail the screen, and as needed be referred for appropriate intervention before 6 months.

The program has reached out to lay midwives to ensure that infants born outside of hospitals are screened for hearing loss. /2013/CSHCN collaborated with partners to establish the electronic exchange of Department newborn hearing and blood screening results with Medical Homes. This effort is in its last year of HRSA funding.//2013//

/2014/Additional access to immunization information, blood screening and hearing screening has been made available through secure access points to authorized users through this project. New legislation takes effect July, 2013 that mandates CMV testing after a 2nd failed hearing screen (HB 81). A Pilot Project will also provide funding for hearing aids for children diagnosed with hearing loss from birth to 3 years (HB 157).//2014//

Specialty Services Program includes the Hearing Screening Program and specialty services, such as physical and occupational therapy, transition and SSI outreach. The program oversees contracts with University and private providers for pediatric specialty care. Transition and SSI information and referral are available statewide through a CSHCN toll free line. CSHCN's transition services focus on a broader education approach for providers and families.

The Maternal and Child Health Bureau oversees five programs, four of which are primarily funded with Title V funding: Data Resources, Maternal and Infant Health, Oral Health and Pregnancy RiskLine. In addition, the Bureau has a Quality Improvement Director. The MCH Bureau oversees local health department contracts for services to mothers, children and youth, and P-5 home visiting. The fifth program in the Bureau is WIC, funded solely with USDA dollars. The Bureau oversees the MCH Block grant application and needs assessment processes with input from CSHCN, Child Development and other Department programs.

The Data Resources Program provides analytic resources and statistical expertise for assessing the health status of the MCH/CSHCN population, planning and evaluating services and is headed by the MCH Epidemiologist with several staff. The staff is proficient in data linkages, such as Medicaid and vital records. The Program assists staff with survey development, database development, and report writing. The program has the lead responsibility for coordination of MCH Block Grant processes each year. In 2012, the program developed the UBID (Utah Block grant Information Data system) system which allows writers to submit materials online. UBID allows staff easier understanding of the block grant requirements for which they are responsible and allows more efficient transfer of information to TVIS.

The Maternal and Infant Health Program (MIHP) is comprised of several components. Preconceptional/Reproductive health focuses on promotion of the importance of good health before pregnancy, reducing unintended or closely spaced pregnancies. The Perinatal Mortality Review program convenes a group of health care providers to reviews infant deaths and pregnancy related maternal deaths to determine if there are factors that might have prevented the deaths. The reviews also provide information on trends in causes of death, such as related to obesity, substance abuse.

The adolescent health component works closely with stakeholders to analyze, prioritize and address critical adolescent issues. This component also includes oversight and management of the federal abstinence only and PREP grants to local communities.

PRAMS (Pregnancy Risk Assessment Monitoring System), funded with CDC and state funds, provides a wealth of information on experiences before, during and after pregnancy that is used to identify issues, develop strategies, and improve the health care systems. The PRAMS staff issue reports on specific topics that arise in the analysis of the data, such as the use of infertility treatments, pregnancy weight gain, gestational diabetes folllow up, preconception health measures, and breastfeeding. ***/2014/ Utah PRAMS was one of five initial pilot states to go live with the new PRAMS data collection system, known as "PIDS".//2014//***

/2014/The Maternal and Infant Health Program is working on initiatives geared towards improving maternal mortality case identification and reviews, improving postpartum follow up testing of women with gestational diabetes, validation of birth certificate data, preterm birth classification, and issues related to non-regulation of single room birthing suites staffed by Lay Direct Entry Midwives (LDEM) and lay midwives.//2014//

Oral Health Program promotes prevention of dental decay and other oral diseases and increased access to services. The program provides technical assistance to local health departments and others in the community. The State Dental Director heads the program and works collaboratively with the Utah Dental Association, Medicaid, community providers and advocates to identify key issues related to the dental health of children and adults. The program works through a coalition of statekholders to promote the importantce of oral health and availability of health insurance covering dental health. The program promotes good oral health, dental sealants, fluoride varnish application and regular dental care. Every five years the program conducts a dental health survey of 6 -- 8 year olds in the schools to assess oral health status. Information from this report is helpful in identifying the needs of children to policy makers.

The Oral Health Program supports fluoride rinse and sealant activities in schools. In fall 2010 the program will survey children ages 6 -- 8 years for dental caries experience. We will compare 2010 results with 2005 data to identify trends and areas of need. Since two large counties have added fluoride to water supplies since 2005, the survey may provide data to measure the impact of water fluoridation.

Pregnancy Risk Line ***/2014/MotherToBaby//2014//*** provides health care providers and consumers with accurate, current information on potential risks to a pregnant woman, fetus or breastfed infant due to exposure to drugs, alcohol, tobacco, chemicals, or infectious agents. Pregnancy Risk Line handles more than over 9,000 calls in a fiscal year. The Program works closely with University of Utah Department of Pediatrics, Genetics and Pharmacy to review current literature to update information on possible harmful effects of medications, infections and other agents, such as chemicals, on the developing fetus or breastfed infant. In the past year Pregnancy Risk Line has addressed antidepressant use in pregnancy,

/2014/ Pregnancy Risk Line has worked with the international Organization of Teratology Information Specialists (OTIS) in developing and implementing the MotherToBaby initiative with the purpose of creating a more consumer-friendly name. Pregnancy Risk Line anticipates effectively reaching more women and health care professionals that benefit from our services, as well as the ability to better engage with key stake-holders and supporting partners.//2014// Pregnancy Risk Line provides training and mentoring for pharmacy, nursing and genetic counseling graduate students. Pregnancy Risk Line collaborates with other agencies to educate about the dangers of alcohol, tobacco and other drugs and resources for treatment. ***/2014/Pregnancy Risk Line continues to participate in numerous research projects aimed at better understanding of the use of medications during pregnancy and breastfeeding and their possible effects on a fetus or breastfed baby. //2014//***

WIC serves more than 67,000 pregnant and postpartum women and young children each year. The program has earned a national reputation of leadership in several areas including the online system for vendors to submit food prices electronically, early implementation of the new food rules, and so on. The WIC Program works closely with other programs on nutrition and obesity. Having WIC in the MCH Bureau has greatly enhanced our ability to work together on common issues and solutions. MCH programs and other programs in the department often consult with WIC nutritionists on breastfeeding and nutritional issues. The Utah WIC Program has been recognized nationally as a leader in innovation and early adopter of new practices.

Quality Improvement Initiative identifies issues related to quality of care for mothers and children. Currently, the Director is working with NICUs on establishing guidelines for appropriate

designation of level of care. The workgroup was recently expanded to add perinatal quality of care in order to bring the life course perspective into the quality improvement realm.

In the Child Development Bureau is the Part C Baby Watch Early Intervention Program, Child Care Licensing, and Early Childhood Utah. The Part C Early Intervention Program serves infants and toddlers with disabilities or developmental delays, and is funded with a combination of state general funds and Federal OSEP funds. The Child Care Licensing Program is funding with a combination of state general funds and Federal CCDF funds, through an interagency agreement with the Utah Department of Workforce Services. Early Childhood Utah is funded with a combination of Federal ECCS and SAC funds

The Office of Home Visiting (OHV), created by a 5 year cooperative agreement with ACF supports infrastructure for implementation of evidence-based home visiting programs to prevent child abuse. OHV supports programs through local collaboration, public awareness of the effects of abuse on children, families and communities and support of evidence-based programs.

Other Programs Funded with Title V Funding:
/2014/School Health Consultant
Utah has few school nurses to oversee the health of school-aged children. We dedicated funding for a School Health Consultant who provides consultation to the State Office of Education, schools, school nurses and others on the health needs of children and youth.//2014//

Violence and Injury Prevention Program, in another Division, works to reduce injury with specific focus on youth injury prevention. The program includes: school injury prevention, youth suicide prevention, pedestrian and bicycle safety, motor vehicle occupant protection, Utah Safe Kids Coalition, and child fatality and domestic violence fatality reviews. The program also works to prevent falls, rape and sexual assault. The program is very active in injury prevention activities and participates with other stakeholders with the state's suicide prevention efforts. The program utilizes Title V funding as well as Prevention Block grant funding and other sources to support its activities. Two youth are treated for suicide attempts every day in Utah.
Utah's suicide rate has been consistently higher than the U.S. rate for the last decade.
/2014/Recent legislation funded two positions to address youth suicide, one in the Office of Education and the other in the Division of Substance Abuse and Mental Health in the Department of Human Services.//2014//

Other programs that serve mothers and children in Utah with other sources of funding
In CSHCN Fostering Healthy Children Program (FHCP), through contract with Division of Child and Family Services (DCFS), is responsible for oversight and coordination of health, dental and mental health needs for children in DCFS custody. CSHCN nurses work with DCFS caseworkers to ensure that all children in state custody get required and follow-up health services. Nurses provide training to biological and foster parents so they can care for the child's health needs. Oversight of health care requirements for children in foster care were mandated by federal court settlement agreement.

In CSHCN Newborn Screening Program oversees the state newborn blood screening of 37 congenital conditions and follow-up for infants with positive screens. The program works closely with birthing hospitals to improve compliance for timely accurate bloodspot samples. CSHCN issues "report cards" for hospitals and providers to improve the quality and timeliness of blood samples. ***/2014/SCID testing will be added in 2014.//2014//***

In CSHCN Travis C. Waiver for Technology Dependent Children, Medicaid's Waiver for Technology Dependent Medically Fragile Children, offers home and community-based alternatives to nursing facility placement for those requiring services of such complexity that they can only be safely and effectively performed by, or under the direction of, skilled nursing professionals. Waiver services augment and extend traditional State plan services including

supportive services to relieve the parent/primary care giver from the stress of providing continuous care. This program is entirely funded by Medicaid and state match funding. ***/2014/Ten additional slots have been added to the waiver this year.//2014//***

In the Bureau of Child Development, the Office of Home Visiting (OHV), created by a 5 year cooperative agreement with the ACF supports infrastructure for implementation of evidence-based home visiting programs to prevent child abuse. OHV supports programs through local collaboration, public awareness of the effects of abuse on children, families and communities and support of evidence-based programs.

Also, in the same Bureau is the Part C Early Intervention Program, Child Care Licensing, Early Childhood Systems Development and the State Advisory Committee.

An Attachment is included for this section.
An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

/2012/In January 2011, Gary Herbert became the 17th Governor of Utah, having succeeded in an election for completion of former Governor Huntsman's term of office. He will hold the office as Governor until 2012 when an election will be held for a full four year term. It is anticipated that Governor Herbert will run for Governor in 2012.//2012// Previously he had served as the Lt. Governor and became Governor when former Governor Jon M. Huntsman, Jr. was appointed by President Obama as Ambassador to China. Governor Herbert had retained the Department of Health's Executive Director, David N. Sundwall, who was originally appointed by Governor Huntsman, through his non-elected term as Governor. /2012/ Dr. David Sundwall resigned as the Executive Director in January 2011. Deputy Director, David Patton, PhD, was appointed to serve as the new Executive Director. Dr. Patton has years of experience in public administration and brings a wealth of experience and expertise in administration to the department. Utah law requires that if the Executive Director is not an MD that a Deputy has to be appointed that is an MD with a degree in public health. Dr. Patton has selected Robert Rolfs, MD, MPH as his deputy executive director. The Executive Director of the Department is a cabinet level position reporting directly to the Governor.//2012// ***/2014/ Gov Herbert retained Dr. Patton upon his election to his first full-term as Governor. //2014//***

Due to discussions among Utah legislators during the 2009 Legislative Session to dismantle the Department of Health /2012/now former Executive Director//2012// Dr. Sundwall initiated a Department-wide reorganization. The reorganization resulted in four divisions being collapsed to three: Division of Family Health and Preparedness, Division of Disease Control and Prevention, and the Division of Medicaid and Health Care Financing. Former Title V Director Dr. George W Delavan retired in June 2009 which provided the Department an opportunity to examine its organizational structure. The reorganization allowed the Department to implement cost savings and align programs in a different way.

/2013/The Utah Department of Health is Utah's Title V agency and is responsible for all aspects of Title V administration. The programs funded by Title V are mainly in two Bureaus in the Division of Family Health and Preparedness: Maternal and Child Health and Children with Special Health Care Needs. A small amount of Title V funding is allocated for oversight of our early childhood efforts in the Bureau of Child Development, another bureau within the Division. The Division of Disease Prevention and Control's Bureau of Health Promotion uses Title V funds for violence and injury prevention and school health. Some Title V funds are contracted to health care providers for specialty services for consultation or direct services.

In addition, local health departments receive Title V funds for maternal and child health services and violence and injury prevention activities. The legislatively mandated Governance Committee which oversees all grants that the Department applies for has reviewed the Title V Block Grant,

but is not convinced that we are allocating the funding to support a statewide public health system. A new pilot process is being implemented for all grants that requires co-chairs, one local and the other state, to oversee the grant planning processes. The MCH Grant is going to pilot the process first. //2013//

Utah's Title V programs, the MCH and CSHCN Bureaus, were moved into a new Division: Family Health and Preparedness. The Division is headed by Marc Babitz, MD, a primary care physician with many years of experience in primary care practice, national and regional positions. The Division also includes EMS, emergency preparedness, and primary care clinics. Unfortunately the Bureau of Health Promotion and the Immunizations Program were moved to the other Division. Dr. Babitz appointed Nan Streeter as the state Title V Director and Deputy Director of the Division of Family Health and Preparedness over the MCH and CSHCN Bureaus and the newly formed Bureau of Child Development (BCD). In addition, Harper Randall, MD was appointed the CD/CSHCN/MCH Medical Director.

/2013/The reorganization of the three Bureaus under one Deputy Director has facilitated improved collaboration, improved oversight of certain programs needing leadership, growth in staff capacity and performance. Programs are working much better, collaborating more and seeing the "big picture" of how MCH, CSHCN and Child Development are all related with each other. We have had discussions of how to apply "life course" in our work and approaches to our programs. In discussions with program managers, it is evident that they are, by and large, applying Life Course, but hadn't perceived it as "Life Course" in particular.//2013//

The Division is organized into six Bureaus comprising approximately 30 programs. Each program reports to a Bureau Director. Since the Division also includes EMS, primary care, and health facility licensure, Title V programs have new opportunities to work more closely with these programs. Title V programs are housed in several bureaus in the Department both in the Division of Family Health and Preparedness and the Division of Chronic Disease Control and Prevention, a sister Division. The Division also includes other programs that address the health of Utah's mothers and children including the state Part C program, WIC program, and others. The senior level management staff of MCH, CSHCN, and CD bureaus brings a wealth of experience and depth of training to their respective program areas. They have the opportunity to lead an expert staff of about 200 individuals to improve the health of Utah's residents. CVs for senior management are attached. The Bureau of Child Development is headed by Teresa Whiting. Teresa has background in child development, child care, Head Start, the State Office of Child Care and child care licensing. She has headed the Department's Bureau of Child Care Licensing, and now has expanded her responsibility to include other programs related to children.

The CSHCN Bureau includes eight programs and the state Part C program, Baby Watch/Early Intervention. /2013/ With Holly Williams' retirement, on July 1, 2012, the new CSHCN Bureau Director is Richard Harward, Au.D. who had been the Program Manager over the Speech and Hearing Program for a number of years. Dr. Harward has extensive experience in management and public health programs. The new Bureau Director is committed to work to better integrate programs with each other and with other Bureaus' programs, strengthen partnerships and establish new ones and ensure that available data are used to evaluate programs and services.//2013// The MCH Bureau includes 5 programs that specifically focus on mothers and children. The MCH Bureau is headed by Nan Streeter, a master's prepared nurse, who brings more than forty years of experience to this position.

The Utah Department of Health is responsible for administration of programs that are carried out with Title V funding by housing the majority of Title V funded programs in the same Division, Family Health and Preparedness distributed among the three bureaus described above. The Department of Health's organizational structure provides for oversight of programs and budgets by program managers, bureau directors and the Division Director. The Department has a number of programs that address the needs of women, mothers, children and adolescents including those with special health care needs, and families. Some programs are fully funded with Title V dollars,

some with partial Title V funding and some that are funded with other sources of monies. In addition, each Bureau oversees contracts that allocate Title V funds to LHDs, CBOs and academic institutions. Local health department funding supports services for mothers and children, P-5 home visiting and injury prevention. With the five year needs assessment, we will review the funding allocations to determine if we are adequately addressing identified priorities with the funding available.

Programs funded by Title V
The program descriptions outlined below provide the services of preventive and primary care to pregnant women, mothers, infants, and children as well as services for children and youth with special health care needs.

Each of the three Bureaus includes programs that specifically address the needs of mothers and children and are funded by Title V funds: the Bureaus of Child Development, Children with Special Health Care Needs and MCH. Bureau of Child Development includes 2 program positions funded with Title V funds, the currently vacant child development specialist and the child health consultant. The Bureau also includes the Head Start State Collaboration Office, the early childhood systems project, Early Intervention (Part C), Office of Home Visiting and child care licensing. Having all the childhood programs together will be advantageous in accomplishing improved collaboration and coordination of efforts.

Programs that focus on mothers and children
The individual programs are described in more detail in Section B.

Child Development
The Bureau includes the child development specialist and the child health consultant, both vacant positions. It also oversees the Early Childhood Systems grant. It also includes BabyWatch/Early Intervention, Child Care Licensing, the Office of Home Visiting, and the Head Start State Collaboration Office. /2012/ The 2010 Legislative Session cut the state funds that were used as match for the federal Head Start State Collaboration Office grant which will result in the Department having to forego future applications for funding beginning July 1, 2011. It is unfortunate that the funding was cut because the purpose of the Bureau of Child Development was to bring together all the early childhood programs to integrate work and activities. It is unknown at this time where the grant will go after June 30, 2011. The Governor is responsible for designating the grantee agency for the state. //2012// /2013/The Governor designated the Department of Workforce Services, Office of Child Care to administer this grant.//2013//

The statewide developmental screening initiative promotes developmental screening of all children birth through five years using the Ages & Stages Questionnaire (ASQ). Staff at local Child Care Resource & Referral agencies train early care and education providers to use the ASQ and share results with parents. The program aims to help early care and education providers connect children and families to community resources for child development.

Surveys to assess the knowledge and use of standardized developmental tools by health care providers were distributed to members of the Utah Chapter of the American Academy of Pediatrics (UCAAP). ***/2014/The preliminary results indicate that the majority of providers who responded use a developmental screening tool.//2014//***

Children and Youth with Special Health Care Needs Programs
The seven CSHCN programs include: Fostering Healthy Children, Newborn Blood Screening, Specialty Services, (including Newborn Hearing Screening), Developmental Consultative Services, Neonatal Follow-up, Utah Birth Defects Network, and the Technology Dependent Waiver programs. /2012/The Pregnancy RiskLine program has been moved to the MCH Bureau to coincide with the Bureau's mission of improving overall health of mothers and children. The program focuses on prevention and therefore really is not a CSHCN program.//2012//

Maternal and Child Health Bureau Programs
The five MCH programs include: Data Resources, Maternal and Infant Health, Oral Health, Pregnancy RiskLine and WIC. The Maternal and Infant Health Program includes PRAMS.

Other programs that reach mothers and children:
Violence and Injury Prevention Program (VIPP) works to reduce injury in the state of Utah, with a specific focus on youth injury prevention. The Baby Your Baby Program (BYB) and other health promotion programs including asthma, diabetes prevention, Tobacco Prevention and Control are housed in a sister Division, but work closely with MCH programs.

A new program was started last year, USDA's Commodity Supplemental Food Program (CSFP), started to take applications in March 2010. CSFP provides supplemental food for eligible women and children as they transition off WIC services and for eligible elderly individuals. ***/2014/The program currently serves approximately 67,000 mothers and children annually.//2014//***

As part of the Department's Strategic Plan, we are working on HUB - Healthy Utah Babies, which is focused on the health of the mother before, during and after pregnancy and the health of her child up to age 5. We are trying to communicate that in order to have a healthy baby, the mother has to be healthy before getting pregnant. HUB is currently working on several areas to accomplish improved health of mothers and their infants: 1) promotion of breastfeeding by promoting WHO's 10 steps for hospitals to support breastfeeding; 2) promotion of preconception health and care through our Power Your Life campaign; 3) reduction in premature births through several avenues: a) promotion of 17P among women who have had a preterm birth; b) promoting long term effective contraceptive methods for women at high risk for preterm births; c) convening a collaborative effort with the 10 tertiary hospitals to promote prematurity reduction and appropriate level of care in NICUs; 4) promotion of universal developmental screening as a means to ensure all young children are screened using an evidence-based screening tool, such as Ages and Stages, and to identify developmental delays early when early intervention is most effective.
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Number and location of Title V program staff
Division staff members are primarily housed at the main Utah Department of Health building, the Martha Hughes Cannon Building, and some are housed at the clinical services building, the Center for Children with Special Health Care Needs. MCH programs are located at the main Department building. In addition to Children with Special Health Care Needs staff at the clinical services building, the Bureau of Child Development staff is also housed there. The Bureau of Child Development houses the Department's early childhood program, child care licensing, early childhood system grant, Office of Home Visiting and BabyWatch/Early Intervention.

CSHCN staff is based at the Center for Children with Special Health Care Needs located adjacent to Primary Children's Medical Center (PCMC) and the University of Utah Health Sciences Center (UUHSC) and within one mile of Utah's Shriners Hospital for Children. CSHCN offers clinical services at the SLC Center as well as in Provo, south of Salt Lake, and Ogden, north of Salt Lake. Some Salt Lake City based staff provide services in outlying areas of the state through itinerant clinics and other state staff is stationed in local communities. For example, twenty-eight nurses work throughout the state in the Fostering Healthy Children Program. The Specialty Services Program has SLC staff and out-stationed staff in the southeast area (Moab) the east (Price) and in Ogden including an occupational therapist, audiologist, a speech pathologist and one support staff. The CSHCN pediatric clinics have 3 out-stationed staff in Ogden, 2 in St. George, a growing community in southern Utah, and contract staff in 7 rural LHD satellite sites to support the CSHCN itinerant clinics.

In 2009 due to budget cuts the Provo multidisciplinary satellite clinic was discontinued and Utah

County children are referred to SLC clinics. In July 2010 Newborn Followup Program clinics in Provo were halved to once a month. The satellite clinic staff is reduced to 3 RNs and 2 support staff. In 2009 CSHCN closed the Cedar City HSVS office and is closing its Price HSVS office this year. Services to these sites will be centralized and provided through itinerant clinics. Senior Level Management

Senior level management is highly experienced in maternal and child health, including children and youth with special health care needs and families, administration, and program planning and evaluation. Marc Babitz, MD is the Director over the Division of Family Health and Preparedness (DFHP).

Three Bureau Directors oversee the Department's MCH/CSHCN programs. Teresa Whiting, with the Department for 4 plus years, oversees the Bureau of Child Development. Teresa has a degree in child and family development and extensive experience in child care, Head Start and program administration. Holly Williams, who oversees the Bureau of Children with Special Health Care Needs, has worked in the Department for 30 years. /2013/Holly is retiring on June 30, 2012. //2013// ***/2014/Richard Harward, AuD, has been hired as the CSHCN Bureau Director with Holly Williams' retirement. Dr. Harward is a pediatric audiologist who most recently has been the Program Manager for Specialty Services, which include audiology, speech pathology, physical and occupational therapy services and oversight of the state EHDI Program. Dr. Harward has also been the project manager for development of the CHARM Data Integration project. //2014//*** Harper Randall, MD, Medical Director of Maternal and Child Health/Children with Special Health Care Needs/Child Development, with extensive experience in community pediatrics, has been with the Department for 6 years. She works with a number of programs, such as autism, newborn blood screening, child death review, perinatal death review etc. The Deputy Director of DFHP, Nan Streeter, is also the state Title V Director and oversees the bureaus of Child Development and CSHCN. She is also responsible for administration of the Maternal and Child Health Bureau programs. Ms. Streeter has been with the Department for more than 20 years.

Division program managers are all well experienced skilled health professionals with significant experience in their field and in program administration, planning and evaluation. Staff that provides planning, evaluation, and data analysis capacity. /2013/The MCH Bureau created a part-time Quality Improvement position to evaluate health care and develop strategies to improve outcomes. One of the QI projects is examining capacity of NICUs and self designation of NICUs as Level III NICUs. This focus is a very sensitive issue to hospitals, especially the smaller hospitals with fewer deliveries, yet designating themselves as Level III NICUs. We have garnered support for our efforts to improve outcomes for babies needing Level III care from the University of Utah as well as from Intermountain Healthcare, the largest health system in Utah. Representatives from the smaller NICUs are concerned about the state examining outcomes since their outcomes follow studies on NICUs with small numbers, that is, poorer outcomes.//2013//

The Office of Public Health Assessment (OPHA) includes Department health survey functions. BRFSS phone follow-up are done by the OPHA survey center. A major strength for the UDOH data infrastructure is the on-line Indicator-Based Information Query System (IBIS). IBIS acts as the primary point of data access and houses numerous data sets all easily accessible for use.

Division planning and evaluation occur primarily at the program level with support from Division and Department data resources. The MCH Epidemiologist ensures that data linking and data related to mothers and children are available to staff. The MCH Epidemiologist, also the Manager of the Data Resources Program, is very skilled and adept for the work and has extensive experience in survey development. The program is an invaluable resource to programs. MCH staff continues to partner with Medicaid to link birth and Medicaid eligibility data to assess birth outcomes among Medicaid women. With the Medicaid Data Warehouse, we have been able to access eligibility and claims data easily. Data Resources staff are skilled in data linkages which is

very helpful in comparing the general population to CHIP and or Medicaid. The MCH Epidemiologist hosts regular meetings of the MCH Epi Network to share data issues related to mothers and children. The MCH Epi Network is well attended by Title V staff and Department staff including the CHD and its offices. The Network addresses critical issues related to MCH and CSHCN to share results or to problem solve an issue. Feedback from Network members has been invaluable for presentations, policy setting and review of data analyses. The Division has successfully submitted abstracts to national meetings for presentation and staff participated in the development of the national preconception health indicators.

A data group for MCH Bureau programs was formed several years ago to discuss common data needs and interests. Originally the focus was only on MCH, but last year, the group was expanded to include CSHCN staff. Initially CSHCN staff was reluctant to participate, but with time more staff has come to the meetings with great interest because they generate ideas and support for work.

Number and role of parents of special needs children and youth on staff
The CSHCN Bureau hired the Director for the Utah Chapter of Family Voices (UFV) as the Bureau family involvement coordinator. She is a parent of five children three of which with special health care needs children with over 25 years of experience in parent advocacy and navigation of the healthcare and disability system of care. She has been involved with the Utah Parent Center (UPC) which is Utah's Parent Training and Information Center federally funded by the Office of Special Education and Rehabilitation Services. She has been very active on the Utah Medical Care Advisory Council for Medicaid, the Utah Legislative Coalition for People with Disabilities and the URLEND project. She has been integrally involved with the establishment of Utah Collaborative Medical Home Project and has provided support to the more than 50 parent and family partners in the individual Medical Home practices across the state.

The Family to Family grant was awarded to Utah Family Voices (UFV) in 2008 and will continue through May 2014. There are many efforts going on at the Federal level to have additional funding for long-term sustainability for the Centers across the country. CSHCN has provided some funding to the Utah Parent Center to support their Autism Hotline and update the on-line Autism resource fact sheet available on their website at http://www.utahparentcenter.org/disabilities/autism/. CSHCN continue to dedicate has dedicated MCH resources available to enhance family-to-family activities and support to families. The F2F maintains a database of family contacts, demographics and issues, With the collaboration of the CSHCN Family Voices director, data is shared with CSHCN to understand what the ongoing needs of families are. Families are compensated for their consultation and expertise when partnering with any of the projects and programs the CSHCN Family Voices director involves them in such as the URLEND program, Medical Home activities, development of materials written for families by families and working with medial residents to provide a parent's perspective. The F2F staff is available as needed to the CSHCN clinics and programs to provide support and resource navigation to families served.

The CSHCN Family Voices director and the F2F staff have provided a series of trainings to families of children with ASD as well as professionals working with them. The training came out of a curriculum developed in collaboration with the URLEND program, CSHCN, Center for Persons with Disabilities and an Integrated Services grant for children with ASD. The F2F trained 20 separate communities throughout the state of Utah over the last year and continues to enhance and adapt the curriculum to the specific needs of the audience. The topics cover everything from adapting to a new diagnosis, to learning about the specific diagnosis, education and community resources, health insurance and financing options as well as emergency preparedness and communication skills. The curriculum also is continuing to evolve into a curriculum for all disabilities that the F2F will provide for all families throughout the state as well including via a web based mechanism. The F2F under the Utah Parent Center and its Board of Directors is actively seeking additional opportunities and funding to sustain the valuable services provided.

The CSHCN Bureau hired the Director for the Utah Chapter of Family Voices (UFV) as the Bureau family leadership coordinator. She is a parent of four special health care needs children with over 20 years of experience in parent self-advocacy training through the Utah Parent Information and Training Center (UPC). She has been very active on the Utah Medical Care Advisory Council for Medicaid, the Utah Legislative Coalition for People with Disabilities and the URLEND project. She has been integrally involved with the establishment of Utah Collaborative Medical Home Project and has provided support to the 23 trained parent advocates in the individual Medical Home practices across the state.

The Family to Family grant was awarded to Utah Family Voices (UFV) in 2008. Services for families continue through the Utah Parent Center, UFV and the Family to Family Health (F2F) Information grant. Although funding for the F2F Information Center has been uncertain, it is probable that HRSA will fund centers through the health reform legislation. CSHCN has provided funds to the Utah Parent Center to support their Autism Hotline. This year, CSHCN reallocated some ASD/DD carryover funding to support the F2F Center because CMS funding ends. CSHCN has dedicated MCH funding to enhance family-to-family activities and support development of a family database. Through this grant two Family Health Partners have been hired and trained to assist in family-to-family health information and education. The funding will reimburse families for their consultation and involvement in development of materials for various projects, such as the F2F project, the Utah Collaborative Medical Home project, the URLEND project and medical residency training. This funding also helped to establish a toll free information and referral line staffed by trained parents. /2013/CSHCN will contract with the Family to Family project to provide consultation and family support to CSHCN clinics and programs.//2013//

Through the F2F grant, a statewide Family Advisory Committee was established which includes families of CYSHCN, a young adult with special needs, key CSHCN staff, private providers and a Medicaid representative. The Utah Collaborative Medical Home Project collaborates with this committee. The committee stakeholders insure that the F2F Center project is effective in addressing the needs of Utah families of children and youth with special health care needs. UFV received a Health Insurance and Financing Technical Assistance Initiative through the federal Maternal Child Health Bureau. With this initiative, UFV has conducted parent focus groups to ascertain issues of health care insurance and financing parents of CYSHCN face. The results will be used to develop a parent focused tool kit for the MedHome Portal website and the findings will be published for key stakeholders to use in outreach efforts and policy development. The Utah Family Voices Director is involved with the Family Advisory Committee at Primary Children's Medical Center (PCMC), Utah's tertiary pediatric facility. The committee will help develop best practice policies for family centered care through PCMC. Issues of discharge planning and linking hospital care to community services for children and youth with special health care needs are being addressed. The advisory committee has been established as a forum in which families of children and youth with special health care needs can resolve issues and problems of hospital care.

The toll-free Baby Your Baby Hotline provides information and referrals on providers and/or financial assistance for prenatal care, family planning, well childcare, nutrition services, or other related services. The hotline staff collaborates well with community resources to ensure that information is current. The hotline is viewed as a valuable resource for both callers and community resources. Budget cuts in 2009 resulted in loss of staff, increasing the workload of the remaining staff. /2013/Since its inception, BYB Presumptive Eligibility has been overseen by the MCH Bureau. A state audit recommended that the Department should move away from the current three Division arrangement (Divisions of Family Health and Preparedness, Medicaid, and Disease Control and Prevention) for better oversight. Enrollment, social media/hotline, and reimbursement for services have been overseen by the three Divisions for many years. MCH Bureau is working with Medicaid to transfer the responsibilities of oversight of the enrollment process and the Qualified Provider orientation and training. This change will be of great benefit to the program so that the agency responsible for the program oversees all the providers that

determine eligibility and that oversight remains with one Division, Medicaid.//2013// ***/2014/ The oversight of Presumptive Eligibility was successfully transferred from the MCH Bureau to Medicaid. Quarterly coordination meetings are held with all divisions involved to ensure the program is running as intended.//2014//***

The Department of Health employs about 174 /2012/now 210 FTEs due to the reorganization.//2012// FTEs at the state level to provide services to the public and infrastructure for addressing the needs of mothers and children, including those with special health care needs and their families. The state staff includes physicians, registered nurses, nutritionists, social workers, psychologists, audiologists, physical and occupational therapists, health educators, and other disciplines.

State staffing has been fairly stable which is helpful for continuity of operations. With the aging public health workforce, the agency has lost or will lose some highly experienced staff. Late 2009, the Department Executive Director offered an "early retirement incentive" if an employee retired before mid-January. A number of employees took advantage of this offer, leaving the agency with vacant positions without the ability to fill them until the Governor lifts the hiring freeze he imposed in January 2010. Given the current economic environment, it is doubtful that staffing will increase in the MCH workforce at present. /2013/We have experienced a number of retirements of staff who have worked for the Department for 20+ years. We are in the process of recruiting to fill those positions, but as with any long term employee, a lot of institutional memory goes with those retiring. //2013// /2013/We have experienced a number of retirements in key staff, such as our Newborn Blood Screening Program Manager, Division Financial Manager and recently the CSHCN Bureau Director. Since we know that we will see additional retirements, we are working to shift some responsibilities around and to enhance the skills of some of the younger staff with potential to assume managerial and administrative responsibilities.//2013//

We do not track staffing or FTEs at local health agencies since they are autonomous. However, it is important to note that one staff member in many districts wears several different hats in their daily work. Each health district has a Health Officer, Nursing Director, WIC Director and other health professionals. Because the state law doesn't require local health officers to be MDs, only two employ an MD as the Health Officer. All Nursing Directors are registered nurses. WIC Directors have various backgrounds with some being Registered Dietitians.

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

E. State Agency Coordination
Utah Title V programs coordinate efforts with numerous other Department programs, and outside agencies such as the Utah State Office of Education, Juvenile Justice, School for the Deaf and Blind, the Office of the Courts, and the Utah Highway Safety Office, LHDs, private not-for- profit organizations and community based agencies to improve the health of mothers, children and children and youth with special needs. /2012/The Division is represented on the state mandated Coordinating Council for People with Disabilities in which all state Divisions serving children and adults with disabilities are represented.//2012//

Mental Health and Social Services/Child Welfare
The Division works closely with the Department of Human Services, which serves the maternal and child population statewide in the areas of child welfare, mental health and substance abuse. For a number of years, the Department staff has sought to strengthen the relationship with the Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) with varying success. Administrative changes in the DSAMH have resulted in a high turnover of staff, including the children's mental health director and Division Director. These changes have made it difficult to engage their staff in our work. Their staff has been involved in our committee work and vice versa, such as DSAMH advisory committees and work with the Pregnancy RiskLine to

promote messages about the impact of alcohol consumption during pregnancy.

The Division has developed a strong collaborative working relationship with the Division of Children and Family Services (DCFS) and Child Protective Services in a number of efforts, including providing services for children in foster care through a contract with the UDOH's Fostering Healthy Children Program (FHC). FHC is an exceptional program that ensures these children and youth receive needed services. CSHCN staff participates on the Health Care Consortium Council for the Division of Child and Family Services (DCFS), which advises the DCFS Board on health issues for children in their system. UDOH Division representatives sit on the DCFS Child Abuse and Neglect Council, and an inter-agency group, Utah Prevention, to address substance use and other issues among youth. Division representatives are part of an inter-agency group to address youth transition issues.

The Baby Watch/Early Intervention (BWEI) Program works with DCFS to develop policy and procedures for CAPTA requirements for referral of children with substantiated abuse and neglect to BWEI. New DCFS procedures require child protective personnel to do developmental screening of children birth to three at the initial home visit. Children who show potential problems are referred to BWEI. Local BWEI agencies partner with local DCFS personnel to train on the developmental screening tool and design referral procedures for children suspected of a developmental delay.

The Interagency Coordinating Council (ICC), which provides advice to the BWEI, has 25 members representing the early childhood services community. The state brings together clinicians, political appointees, parents of special needs children, and administrative representatives of various agencies or providers such as mental health, human services, education, Department of Insurance, Head Start, Workforce Services, Division of Services for People with Disabilities, physicians and representatives from Early Intervention providers to provide a broad vision of the service system based upon the participation and contributions of providers and consumers.

Education
The Department works with the State Office of Education (USOE) on a variety of projects and issues, such as adolescent health, special education, school health. /2012/and state vocational rehabilitation services.//2012// Previous difficulties in working with the State Office have resolved and we find the staff to be very supportive of collaboration with us. The Department engaged the State Office in discussions of submitting a grant to CDC on comprehensive school health and they have been very enthusiastic and supportive of this particular collaboration with the Department. UDOH has started a working committee to include the State Office staff to address issues related to school health. State Office staff is excited about this opportunity and have been supportive of what the Department wants to do to improve school health. USOE would apply for the next funding cycle for the CDC Coordinated School Health grant. USOE and UDOH staff is very interested in submitting a grant application probably in 2012 or 2013. We will continue momentum to work on school health regardless so that we can address the many needs of school age children and youth. The MIHP collaborated with the USOE and Planned Parenthood of Utah on an Adolescent Preconception Health Initiative supported by AMCHP. USOE was actively involved in this initiative. CSHCN Bureau and the Office of Students at Risk (SARS), the state special education program, enjoy a strong working relationship and have collaborated on a number of projects, such as Medical Home and the development of several learning modules on the MedHome Portal. A SARS staff member sits on the Medical Home Advisory Committee. CSHCN Bureau and SARS have worked together on the Utah Registry for Autism and Developmental Delays (URADD) grant. /2012/UDOH has a School Health Consultant to address health issues in schools and work with the Office of Education and school nurses.//2012//

Corrections
Traditionally the Division has not worked much with Corrections, however during the past year Maternal and Infant Health Program staff has initiated discussions with prison officials on

providing education to female inmates on family planning. Data have shown us that many women of childbearing ages who have unintended pregnancies report using a contraceptive method, obviously incorrectly, or report non-use, requiring some education about contraception and its various methods. Women in prison and those transitioning to parole need this information to make informed decisions about their reproductive lives.

Medicaid
The Utah Department of Health houses the state Medicaid agency and very fortunately Title V enjoys a strong relationship with Medicaid. Since Utah's CHIP Program, a stand-alone program, is administered by Medicaid, we are able to collaborate with the CHIP Program as well. The Division works closely with Medicaid staff on pregnancy related services, EPSDT, oral health and other Medicaid administered programs that serve mothers and children. Medicaid provides match for a number of our programs that serve the Medicaid populations, such as Baby Your Baby outreach, PRAMS, etc. Medicaid developed a targeted case management (TCM) model for children up to age four in collaboration with Title V staff.

The Maternal and Infant Health Program has worked with Medicaid to certify smoking cessation interventions for pregnant Medicaid participants; provide case management to a subset of high risk pregnant Medicaid women in Salt Lake County; and to ensure information for, outreach to, and access for Medicaid eligible children and youth with special health care needs and their families. ***/2014/ The MCH Bureau applied, and was accepted, for an AMCHP Action Learning Collaborative on Improving Birth Outcomes through health care reform. Through this process, the MCH Bureau will work with Medicaid and community partners to leverage the Affordable Care Act to improve birth outcomes.//2014/***

The MCH/CSHCN/CD Medical Director is a member of Medicaid's Utilization Review and CHEC/EPSDT Expanded Services Committee, which meets twice a month to determine authorization for non-covered services for Medicaid recipients. The CSHCN Bureau Director and Medical Director serve on Medicaid committees and assist Medicaid with authorization of needed services for children with special needs. The Medical Director, State Dental Director and physical therapist sit on the CHEC authorization committee, but voting privileges are held only by the Medical Director and the Dental Director.

The CSHCN Family Voices Director was a member of the Medical Care Advisory Committee for Medicaid for over nine years, as the term ended the UFV Director identified another parent of a child with special health care needs to represent the family and consumer voices. The new member of the committee also works with the Family to Family Health Information Center.

/2012/ The Medical Director played a key role in the development of a proposal from Medicaid for an ASD waiver which was presented to the Utah legislature.//2012// The Medical Director started quarterly meetings with Medicaid and the UUHSC Genetics Director to improve the coordination of EPSDT coverage of genetic testing for children.

The Oral Health Program has well-established relationships with Medicaid and CHIP to improve accessibility to Medicaid/CHIP dental services. Program staff collaborated in defining a basic scope of CHIP dental benefits; ensuring that eligible children can be seen by "any willing provider"; and, expanding CHEC (EPSDT) outreach programs for case management for children needing dental services. Program staff has been instrumental in working with Medicaid to cover fluoride varnish application by non-dental providers, i.e., pediatricians. Medicaid identified a medical billing code for this service for pediatric providers. SSI, DDS and Vocation Rehabilitation.

The SSI Specialist position in CSHCN, established over ten years ago, continues to work with the Office of Disability Determination Services (DDS) that evaluates disability claims for SSI eligibility by reviewing DDS claims and providing outreach and referral for

potentially Medicaid eligible children. The specialist provides information, referral and enabling services to families having difficulty accessing or utilizing services, such as Utah Legal Services, Disability Law Center or DDS. /2012/The CSHCN Bureau Director has participated for 5 years on the State Rehabilitation Council, advisory for all state vocational rehabilitation services provided through the Office of Education.//2012// CSHCN staff is active in the Utah Center for Assistive Technology Center under Vocational Rehabilitation on advisory boards and coordinating direct care for individuals with disabilities.

Local public health agencies
The relationship between the local health departments (LHDs) and the MCH/CSHCN programs has had a strong history of working together, often in spite of tensions between the Department and the local health officers. Fortunately program staff generally does well in relating to their colleagues in the LHDs.

However, the relationship between the Department of Health and the LHDs reached such a level of conflict that it has been very difficult to proceed with any effort involving LHDs. In fact, LHD leadership supported a bill in 2009 that mandates UDOH to present any federal grant application to a Governance Committee consisting of UDOH representatives and local health officers. The local health officers are seeking additional funding from federal grants that could be allocated to the LHDs because they believe UDOH is keeping an unfair share of the funding. The Governance Committee was formed early in 2009 and went into effect July 2010. It remains to be seen how this process will work to improve services at the state and local level. To date, the Governance Committee has reviewed several grants and no funding has shifted to the LHDs because they are infrastructure grants. /2012/The Governance Committee assigned review of the Title V Block Grant to six UDOH staff and six LHD staff. The group started meeting in February 2011 and will continue to meet to discuss the grant and reach consensus on recommendations for the Governance Committee.//2012//

/2013/The relationship between the Department of Health and the local health departments is slowly improving and becoming more positive. Through the efforts of the Department's leadership and the local health department leadership, we are making strides in building a more collaborative partnership. The Department has initiated a number of different efforts to address the need for better collaboration, such as working to develop a Statewide Public Health Improvement Plan and so forth.//2013//

/2014/The relationship between the Department and most local health departments has greatly improved over the past several years. The Department leadership along with strong LHD leadership have made a number of concerted efforts to enhance the relationship, improve communications, increase awareness of the challenges that public health faces at a state and at local levels.//2014//

The Department provides Title V funds to LHDs via contracts. More about the LHD role in providing services for mothers and children is included in the Section B. State staff meets with local health officers and nursing directors during their meetings as needed or requested. Representatives of the local health officer association and the local nursing director association participate in various Division advisory committees or task forces to ensure their input and support.

Federally qualified health centers and state primary care association
While the relationship with community health centers (CHC) is positive and collegial, it always needs nurturing. Some LHDs see CHCs as "competitors" rather than a community resource which obviously doesn't support collaboration between the two entities. In fact, one local health department and community health center do not work together at all due to bad feelings that have developed between the two agencies.

However, UDOH has a positive relationship with the CHCs and the Primary Care Association, AUCH, Association for Utah Community Health. With Department reorganization, Title V programs are in the same Division as the Primary Care Office which will enable us to work more closely. Division staff has a strong collaborative relationship with the State Primary Care Association and the community health centers by invitations to sit on Division advisory committees, etc. We have a very small contract with the Salt Lake Community Health Center for prenatal care for uninsured women.

The Oral Health Program works with AUCH, Utah's PCA, to provide technical assistance to their dental clinics and encourage the addition of dental clinics in other community health centers. Now that the Title V programs are in the same division, we expect to work more closely with state and local staff. /2012/Unfortunately the state legislators cut primary care grant funds to CHCs because they believe the CHCs get adequate funding from the federal government. UDOH will have to cut any contracts with CHCs per Legislative intent.//2012//

Title V staff has for the past several years been invited to review grants submitted by community organizations and LHDs for the Department's primary care grant program. This program is important as it funds clinics and/or services that would otherwise not be available. Grants are awarded to agencies in urban and rural/frontier areas of the state. Unfortunately state funding cuts for this program have reduced the number of grants available. Projects funded include many to improve oral health, family planning, mental health and other services that are needed by MCH populations in communities.

Professional organizations:
The MCH/CSHCN Medical Director sits on the Executive Committee of the Utah Chapter of the American Academy of Pediatrics. Staff works with members of the Utah Chapters of the American College of Ob/Gyn, the American College of Family Practice and the American College of Certified Nurse Midwives on various projects.

Tertiary care facilities
The Division has effective relationships with many of the tertiary facilities in the state, seven perinatal centers and two children's centers. The Newborn Follow-up Program provides outcome data to the newborn intensive care units in the state. The University of Utah Health Sciences Center, a tertiary perinatal center, works closely with MCH Bureau staff on various grant projects. Our staff often provides linked datasets to the University for studies or grant applications. /2012/The Maternal and Infant Health Program queried all delivering hospitals on neonatal care and capacity related to provider types, availability, and support services. Ten facilities self designate as Level III, but only three met the AAP criteria. The Program met with hospital representatives to discuss survey results and to discuss criteria for Level III designation. The definition of "continuously available" is the sticking point in defining Level III.//2012// 2013/MCH staff worked with the University of Utah Department of Obstetrics and Gynecology on a Strong Start grant that the UofU submitted to CMS. The grant will be a collaborative effort among the UofU, CHCs, Intermountain Healthcare, Medicaid ACOs, Medicaid and MCH to identify women at high risk for preterm birth.//2013// ***/2014/Unfortunately Utah was not funded to implement this grant.//2014//***

/2012/The Perinatal Mortality Review Committee engages medical staff from the UofU neonatology and maternal fetal medicine to review infant deaths due to perinatal conditions and women of childbearing ages who die within 12 months of a pregnancy. The Committee reviews each case to determine if the death could have been prevented.//2012//

Primary Children's Medical Center (PCMC) and Shriners Hospital for Children, the two children's hospitals in the state, work closely with CSHCN to coordinate services. PCMC physicians /2012/as well as the MCH/CSHCN Medical Director//2012// participate in the Department's Child Fatality Review Committee to identify those deaths that possibly are preventable. The

MCH/CSHCN/CD Medical Director is involved in University of Utah and PCMC based health services research committee. The CSHCN Family Voices Director works closely with the Family Advisory Council at PCMC and has the staff at the F2F also involved with the committee. One of the staff members was selected to be on the PCMC Board of Trustee, which is the first "Parent" member. The CSHCN Family Voices Director sits on the committees of the URLEND program, the Medical Home Portal, and UPIQ which provides education and information through professionals to outreach and support families of children and youth with special health care needs throughout the state.

CSHCN continues to support medical homes through the UFV Director's direct consultation and site visits as requested to the clinics in the CHIPRA grant and other UPIQ Medical Home projects. CSHCN also continues the collaboration with University of Utah, Department of Pediatrics and Utah State University, Center for Persons with Disabilities in providing interdisciplinary leadership training to trainees in the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND).

Pediatricians from the UofU Department of Pediatrics are contracted to provide developmental pediatric assessments at CSHCN Salt Lake City and satellite clinics. Neurologists and geneticists from the UofU are contracted to provide sub-specialty evaluations at CSHCN satellite clinics. Intermountain Healthcare, the state's largest health system, owns four perinatal centers and one pediatric tertiary care center. Department staff works with providers in these centers on a number of initiatives, including induction policies, appropriate delivery site for very low birth weight infants, electronic medical records, Perinatal Task Force, etc.

Public health and health professional educational programs and universities
Two universities and a private college offer a Master of Public Health degree (UofU, Brigham Young University and Westminster College). The UofU also offers a PhD in Public Health. The programs focus on more traditional public health and have no specific focus on maternal and children health, but rather a more traditional public health focus. /2013/ The Department is often asked to "mentor" students or to assist them with a project required for completion of a degree. We promote the importance of state-level work in public health as it seems there is more focus on local public health. For example, we will get requests from the UofU, BYU and Weber State to provide internships to students from nursing, health education, pharmacy, genetics and so on. We believe that it is our responsibility to train and mentor students in the work we do at the state level.//2013//

The Utah Department of Health developed the Great Basin Public Health Leadership Institute, (GBPHLI) with the Nevada State Health Department. GBPHLI graduated its first class in 2005. The program continues to enhance Department leadership capacity.

MCH and CSHCN staff has been involved with several colleges and Universities in the state as well as out of state providing internships for students in these programs and others, such as nursing, pharmacy, pediatric medicine, social work, dental hygiene, and health education. CSHCN provides internship sites for University of Utah audiologists, social workers and clinical experiences for students and trainees through its multi-disciplinary clinics and through the Pregnancy RiskLine.

UofU faculty from different departments is involved in a number of Department efforts to improve the health of mothers and children, such as advisory committees, the Perinatal Mortality Review program, Child Fatality Review Committee PRAMS Advisory Committee, and others. The UofU Departments of Family and Preventive Medicine and Obstetrics and Gynecology invite Division staff to collaborate on a perinatal Epidemiology workgroup for projects related to mothers and children. The Department of Obstetrics and Gynecology often asks our MCH Epidemiologist to compile data sets for analysis, to support grant applications and grant requirements, such as a NIH-funded fetal death project. Faculty members are available for technical and clinical questions.

UofU Pediatric faculty serves on CSHCN advisory committees, including the Early Intervention Inter-agency Coordinating Council, the Medical Home Advisory Council, the Newborn Hearing Screening Advisory Committee and the Genetics Advisory Committee. The Medical Home Advisory Committee was dissolved at the end of the HRSA grant and the membership was revamped into the CSHCN Executive Group (CEG) to include key community advisors to CSHCN, including the UofU Department of Pediatrics, Utah State University (USU) Center for People with Disabilities, and Utah Family Voices. Other partners are invited to participate as specific issues arise. The CEG meets quarterly.

Utah CSHCN is in its third /2012/tenth//2012// year of the MCHB-funded Utah /2012/Regional//2012// Leadership Education in Neurodevelopmental Disabilities (ULEND) program. CSHCN collaborates with USU Center for Persons with Disabilities and University of Utah, Department of Pediatrics, in an MCHB Leadership Grant. URLEND provides opportunities for students and professionals in health related disciplines (pediatrics, physical and occupational therapy, speech-language pathology, psychology, nutrition, social work, audiology, pediatric dentistry, genetics, nursing, business/marketing, special education and families) to increase their knowledge and skills in providing services and supports to children with neurodevelopmental disabilities. CSHCN collaborates with the URLEND supplemental grants, in its fifth /2012/tenth//2012// year for audiology and ASD. /2012/A new URLEND application has been submitted to continue for the next 5 years.//2012//

Other federal grant programs
The Division is the recipient of a number of federal grants from Education, CDC, USDA, HRSA, etc., including Early Intervention (Part C), SSDI. WIC, PRAMS, Autism, EDHI, Lost to Follow up, Home Visiting, IT, Critical Congenital Heart Disease, Abstinence Education and the Personal Responsibility Education Program (PREP) and others as they become available.

WIC
The state WIC Program which is in the MCH Bureau greatly enhances opportunities for coordination of efforts. WIC has a strong collaboration with other programs focused on the health needs of mothers and children. Other programs have enthusiastically welcomed the collaboration opportunities with WIC. WIC staff members participate on various committees related to maternal and child health, including the Perinatal Task Force, MCH Epidemiology, nutrition, and data integration efforts. The challenge remains, however, to get local agencies to view WIC as a program that has opportunities to promote healthy mothers and children through collaboration and integration of services. WIC funds a half-time data analyst in the Data Resources Program to support review and analysis of WIC data. Program staff has much improved access to use of WIC data for program planning.

Family Planning Programs
The Title V agency has enjoyed a very strong relationship with the state Title X agency, Planned Parenthood Association of Utah (PPAU). The Chief Executive Officer of PPAU has participated for a number of years on various advisory committees and task forces to address the needs of women of reproductive age in the state. The Maternal and Infant Health Program provides technical assistance and consultation to LHDs on family planning services, methods and their use.

Family Leadership and Support Programs
CSHCN employs the Utah Family Voices Director to lead the Family Involvement, Leadership and Support programs which provide consultation and support to CSHCN programs and families, and to infuse and enhance family-centered values into CSHCN Bureau programs and initiatives. Family Voices has successfully applied for and awarded funding to continue the Family to Family Health Information Center (F2F) through fiscal year 2013. The F2F is housed in the Utah Parent Center a federally funded Parent Training and Information Center.The F2F provide direct consultation with information, resources and peer to peer support to families through various

mechanisms. Families connect with the CSHCN Family Voices Director and F2F staff in person, by phone which includes a toll-free line, electronically through email and social media and trainings throughout the state. Both the Utah Parent Center and Utah Family Voices provide the services above as well as provide leadership training and mentoring for families. The model of collaboration between the UPC and F2F effectively provides comprehensive services of each of the Centers expertise .The UPC provides top quality services related to Special Education, the F2F provides valuable services related to the healthcare and financing system and both partner to provide services related to home and community based resources and systems of careStaff at both Centers are parents of children with special health care needs and disabilities. All staff participates on local, state and national level committees to provide a parent's voice and perspective to systems change efforts and policy-making. The F2F and the UPC are engaging in projects and collaboration with the state's Federation of Families project (Allies with Families) and the Division of Human Services to partner in providing supports to families who have children with emotional, behavioral and neurobiological disorders. The integration of children's mental health within Medical Homes has been a focus for the CSHCN Family Voices Director and the F2F and the training of Family Resource Facilitators in the Mental Health centers is the focus of the UPC and Allies with Families. Efforts to continually enhance integration between parent-run initiative only helps to provide as many family voices into the system as possible for better outcomes for all children, youth and their families. The state has greatly benefited from family involvement in programs and hopes to expand efforts so that more programs have family support to better address the needs of families with CYSHCN.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	17.0	17.2	14.3	17.5	17.5
Numerator	451	461	389	460	460
Denominator	265602	268059	272653	262121	262121
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2011
Data reported are the most recent data available.
Numerator: Hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2010

Data reported are the most recent data available.
Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2010
Denominator: IBIS Population estimates for 2010

Narrative:
a.

The Asthma Program, through CDC funding, has conducted several activities to help children under five manage asthma. During the past four years, child care providers have been trained to encourage asthma-friendly child care environments and to teach care givers to recognize and manage asthma symptoms. In 2012, a Telehealth session was held addressing ways to improve provider-patient communication and self-management among pediatric asthma patients. Several members of the Utah Asthma Task Force, comprised of various community and professional partners, conducted focus groups for mothers of children under five and developed asthma educational materials based on the results. Materials were distributed through various partners including the Baby Your Baby Program. The Asthma Program funded the Weber-Morgan Health Department to work with the Community Action Partnership to increase awareness of asthma resources and improve asthma management among Head Start families and train staff parents at monthly meetings.

b.

The Asthma Program develops strategies according to its Utah Asthma Plan, which was updated for 2012-2016. The State Plan is written to address several aspects of Utah's communities including schools, health systems, environment, and others.

The Asthma Program added numerous resources for health care providers and the public to its website. These include a health care provider manual addressing guidelines to manage pediatric and adult asthma as well as a guide to asthma medications. The Asthma Program has held over ten quarterly Telehealth sessions to educate health care providers across the state on various asthma-related health issues. The Green and Healthy Homes Initiative was established in Salt Lake City in 2012. This program will help reduce asthma triggers in homes and provide education on how to manage and prevent asthma symptoms. Guidelines were developed about mold and its dangers and how to safely eradicate it. Online tutorials for the public on air quality and asthma were published on the website.

c.

In 2011, the asthma hospitalization rate for children less than five years of age was 17.6 hospitalizations per 10,000 population which is beneath the Health People 2020 Goal of 18.1 per 10,000, and well below the baseline of 41.4 in 2007. These data indicate that interventions and asthma education around the state may have had a positive impact. However, the rate of change over the last 5 years in Utah has not been statistically different. This suggests a need for a stronger focus on educating care-takers about asthma symptoms and management in children under 5.

Several pockets in the state have been found with higher than average asthma hospitalization rates. The distribution of areas with increased rates has been puzzling because one community with a high rate is adjacent to one with a lower rate. The Asthma Program continues to conduct surveillance to determine reasons for the differences.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	87.4	83.0	83.9	89.0	88.4
Numerator	19088	18803	18803	15475	14719
Denominator	21831	22647	22404	17393	16644
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
The calculation for this measure has been revised since 2010. Data are not comparable with previous years.

Numerator: CMS 416 for FFY 2012: total eligibles receiving at least one initial or periodic screen (line 9)
Denominator: CMS 416 for FFY 2012: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.88 (line 10)

Notes - 2011
The calculation for this measure has been revised since 2010. Data are not comparable with previous years.

Numerator: CMS 416 for FFY 2011: total eligibles receiving at least one initial or periodic screen (line 9)
Denominator: CMS 416 for FFY 2011: total eligibles who should receive at least one initial or periodic screen (line 8)

Participation ratio 0.89 (line 10)

Notes - 2010
Data reported are the most recent data available.
Numerator: CMS 416 for FFY 2010
Denominator: CMS 416 for FFY 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

This indicator has improved which is a positive move in getting more infants care than in previous years. Because the SCHIP program is open continuously and applicants apply for SCHIP and Medicaid at the same time, more children are likely to be enrolled in Medicaid than in the past. However, the indicator really doesn't measure the extent to which Medicaid children are getting regular periodic screenings during the first year of life. A better indicator would be children's screen visits versus the recommended number of visits for the first year.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

Medicaid contracts with each local health department for CHEC (Utah's EPSDT) outreach to assist families in accessing insurance coverage and health care services.

The local health departments also provide targeted case management services for Medicaid children under age 5, which include education about the importance of the well child visits, especially for children under one year, and referrals to needed health care services when appropriate.

A barrier to access to care is the fact that the Medicaid reimbursement rate for health care providers is low and thus, fewer providers are willing to accept low Medicaid reimbursement rates.

Title V will continue to work closely with Medicaid to develop better strategies to improve access to health care for infants.

c. Interpretation of what the data indicate:

The percent of Medicaid enrollees under age one receiving at least one initial periodic screen has remained steady from 88.9% in 2011 to 88.4% in 2012. The steady rate may be indicative of efforts to improve access to care for infants on Medicaid through outreach workers assisting families as well as targeted case management services which assist families in accessing needed health care.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	99.3	97.6	97.1	97.8	97.8
Numerator	286	283	299	175	175
Denominator	288	290	308	179	179
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Numerator: HEDIS measure “Well Child Visits in First 15 Months” HCS 2012
Denominator: HEDIS number of children under one in CHIP, HCS 2012

Notes - 2011
Data reported are the most recent data available.
Numerator: HEDIS measure “Well Child Visits in First 15 Months” 2011
Denominator: HEDIS number of children under one in CHIP, 2011

Notes - 2010
Data reported are the most recent data available.
Numerator: HEDIS measure “Well Child Visits in First 15 Months” 2010
Denominator: HEDIS number of children under one in CHIP, 2010

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCI?

The HEDIS data as reported by the CHIP participating health plans assist us in determining the need for ongoing efforts to ensure children receive needed services. In 2005 the CHIP health plans started utilizing a combination hybrid and administrative data collection methodology designed to better capture the information.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

Regardless of the reason for the increase, we are very pleased to see the ongoing improvement in screenings among this population of infants. Lessons learned from the CHIP population might be applicable to infants on Medicaid to improve its periodic screening rates, although the low Medicaid reimbursement rates continue to limit access to care for Medicaid children.

c. Interpretation of what the data indicate:

This Health System Capacity Indicator has shown dramatic improvement. In 2002 only 53.5% of infants had received a periodic screen and in 2012, 97.8% received a service. The increases may be due to better reporting of information.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	82.5	82.8	84.5	84.9	84.9
Numerator	44643	41794	41430	41269	41269
Denominator	54085	50475	49010	48596	48596
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2011
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2010
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

Eligibility for Utah Prenatal Medicaid is at the lowest allowable income level. Utah women's income must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. In addition, Utah is one of only six states that requires an asset test to qualify for Medicaid. Because of these policies, many working poor women who may be eligible in other states across the country are not eligible in Utah and have to self-pay for prenatal care affecting entry into and adequacy of prenatal care. We note a growing population of women who are not eligible for Prenatal Medicaid due to citizenship status, which interferes with early and continuous prenatal care. With a limited number of safety net providers, access to care is very difficult for this needy population. The Maternal and Infant Health Program contracts with the Salt Lake City Community Health Centers Inc. to provide prenatal services for uninsured pregnant women who reside within the city limits, but funding is woefully inadequate to cover the need. Due to contractual issues, the Baby Your Baby media campaign that encourages women to get early and continuous prenatal care was suspended and no ads were run in 2012.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

We continue to promote safety net providers that cover uninsured women. The UtahClicks online enrollment application system provides easy access for pregnant women to begin their Presumptive Eligibility process to enroll in prenatal Medicaid. In FY13, the Maternal and Infant Health Program returned oversight of Presumptive Eligibility enrollment to Medicaid. MCH staff holds quarterly coordination meetings with the Medicaid staff involved in oversight of "Baby Your Baby". In FY13, a new contract was secured to resume the Baby Your Baby media campaign. Remarketing of Baby Your Baby will include presences on Twitter, Pinterest and a Baby Your Baby Blog.

c. Interpretation of what the data indicate:

In 2011, 84.9% of Utah women ages 15-44 delivering a live infant received adequate prenatal care based on the Kotelchuck Index. Among Hispanic women, 74.4% received adequate prenatal care compared to 86.9% of non- Hispanics. This disparity is likely due to the large number of immigrants in Utah who do not qualify for Prenatal Medicaid due to immigration status or other criteria. While Hispanic mothers receive some prenatal care, because they are uninsured and paying out of pocket, they may be much more likely to skip visits. The lower rate may also reflect different cultural norms among Hispanic women who may see pregnancy as a time of health instead of a time to seek medical care. Higher rates of inadequate prenatal care occur among women who are younger, less educated, and unmarried. Women who reside in rural areas also have lower rates.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	86.6	86.6	84.6	69.1	56.9
Numerator	142476	142476	166381	94830	93354
Denominator	164602	164602	196665	137236	163947
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
The calculation for this measure has been revised since 2010. The data are not comparable with previous years.

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2012 data (ages 0 - 20)
(line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2012 data (ages 0 - 20) (line 8)

Participation ratio .57 (line 10)

* The rate now includes data for infants and 19 - 20 year olds.

Notes - 2011
The calculation for this measure has been revised since 2010. The data are not comparable with previous years.

Numerator: CMS 416, Annual EPSDT Participation: Total eligibles receiving at least one initial or periodic screen, 2011 data (ages 0 - 20)
(line 9)

Denominator: CMS 416, Annual EPSDT Participation: Total eligibles who should receive at least one initial or periodic screen, 2011 data (ages 0 - 20) (line 8)

Participation ratio .69 (line 10)

* The rate now includes data for infants and 19 - 20 year olds.

Notes - 2010
Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid from Medicaid Data Warehouse, 2010.

Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the BRFSS 2010.

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

This indicator has shown a decline from 69.1% in 2011 to 56.9% in 2012. We need to increase our efforts to ensure that Utah children enrolled in Medicaid are receiving needed health care services.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

This is an area for Medicaid and the Department of Workforce Services (they do Medicaid enrollment) to address with our support. We will meet with Medicaid to illustrate the decline in

accessing services and work with them to develop better strategies to improve in this area.

c. Interpretation of what the data indicate:

We are not sure what the data mean other than the obvious fact that fewer children enrolled in Medicaid are receiving services. Perhaps efforts in targeted case management are not as effective, although those services are only available up to age 5. We will look at the age groups that are not receiving services to identify particular ages when children aren't receiving services.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	51.4	52.6	54.3	54.8	57.0
Numerator	15211	18550	21772	24516	26694
Denominator	29599	35280	40125	44736	46861
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Numerator: Medicaid CMS 416, FFY2012
Denominator: Medicaid CMS 416, FFY2012

Notes - 2011
Data reported are the most recent data available.
Numerator: Medicaid CMS 416, FFY2011
Denominator: Medicaid CMS 416, FFY2011

Notes - 2010
Data reported are the most recent data available.
Numerator: Medicaid CMS 416, FFY2010
Denominator: Medicaid CMS 416, FFY2010

Narrative:
a.

There has been an improvement in the percentage of children receiving dental services, in part, due to the emphasis that the Oral Health Program (OHP) has placed on early childhood dental caries prevention and education as well as the need for early and regular dental visits. The OHP has collaborated with the Utah Oral Health Coalition in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits for children.

b.

The OHP collaborated with staff in the UDOH Division of Medicaid and Health Financing to expand current CHEC Utah's EPSDT) outreach programs. Through these expanded efforts,

outreach workers have provided a higher level of case management for children needing dental services. The CHEC dental case management system has been implemented in all local health departments. CHEC outreach staff are responsible for: 1) conducting outreach to encourage use of preventive and follow-up services; 2) educating children and parents about CHEC benefits and the importance of keeping appointments; 3) working with parents to help reduce barriers to accessing care such as transportation, childcare, language, etc.; 4) serving as liaisons with dental offices to recruit and encourage dentists to become Medicaid providers. In addition, Medicaid staff has worked with dental office staff on billing and other issues to reduce identified barriers to care. The State Dental Director has been working with the Utah Dental Association Access Committee to encourage dentists to see Medicaid eligible children to improve the percent receiving early and regular dental care. The Dental Director meets with members of local dental districts around the state to promote increased access for children to dental services.

The OHP has worked with the Utah Oral Health Coalition and Dental Select in the refinement and expansion of the "Sealant for Smiles" program. Second and sixth grade students from Salt Lake, Davis and Tooele counties Title I schools are provided dental education, screened for dental disease and have fluoride varnish and dental sealants placed. Care is coordinated for those students who have dental needs. Plans are to take the sealant program statewide.

The OHP has collaborated with the Utah Oral Health Coalition and the Salt Lake County Health Department in researching oral health education materials/curriculum and have endorsed the American Dental Association program which is being used in elementary schools to increase awareness of good oral hygiene habits and the value of early and regular visits to the dentist.

c.

Data indicate that efforts to increase access to dental care for this population have been successful but that ongoing work is necessary to assure that Medicaid children have access to routine dental care.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	23.1	18.7	15.8	8.8	9.6
Numerator	981	846	743	427	482
Denominator	4239	4522	4709	4845	5019
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2012
Numerator: CSHCN DDS Log and MegaWest data, 2012

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2012

Notes - 2011
Numerator: Unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN DDS Log and MegaWest data, 2011

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2011

Reason for the decrease in percent (15.8% to 8.8%) is due to seeing fewer and fewer children due to budget cuts.

Notes - 2010
Numerator: Unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN DDS Log and MegaWest data, 2010

Denominator: Children under 16 receiving SSI, SSI data for calendar year 2010

Narrative:
a.

Sufficient information about possible SSI eligibility may be lacking thus limiting application for new eligibility and receipt of services. Data from DDS (Disability Determination Services) to CSHCN (Children with Special Health Care Needs) is processed by two people for completeness and will process the information faster. Client information is now sent to Electronic Records Express. We have been able to access the Social Security information that DDS sends to us much quicker than in the past through a secure system.

b.

Children who have SSI are generally eligible for Medicaid, although the application processes are separate. CSHCN encourages families to apply for Medicaid because SSI/Medicaid allows children a broader array of services beyond those provided by CHIP or CSHCN clinics.

The CSHCN Bureau employs an SSI Specialist who works with the Office of Disability Determination Services (DDS). As a member of the DDS Advisory Council, the Specialist offers consultation on DDS policy and service administration and fosters the relations among SSI/DDS, Medicaid and CSHCN. DDS sends referrals for all potential recipients up to age 18 years, for the Specialist for outreach and information about potential Medicaid eligibility, as well as community resources. The Specialist provides information, referral and enabling services to families whose children have been denied disability and need support with reconsiderations or hearings for SSI, Medicaid or CHIP eligibility. The Specialist is English/Spanish speaking and works with Spanish speaking families. These English/Spanish Speaking families are referred to resources like Utah Legal Services, Disability Law Center or other consulting staff or agencies.

CSHCN also employs a transition specialist who provides information, consultation, and support to CSHCN Bureau staff and itinerant staff on adolescent and young adult transition services. Staff training is provided on identification of potential candidates for SSI participation and increasing successful referrals.

CSHCN focuses on reporting of SSI coverage by parents and our clinicians. Intake staff ask each time a CSHCN client comes to clinic about their SSI eligibility. Our SSI specialist keeps the DDS log updated from the information DDS sends. An informational letter is sent in a timely manner to inform families they may be eligible for Medicaid "D" and they need to apply. Many families call due to the letter and seek counsel in SSI/ Medicaid matters.

c.

These data indicate that for 2011, the percent of identified SSI beneficiaries who received rehabilitative evaluation services increased (8.8% to 9.6%). CSHCN has changed to an electronic charting system/database. We may be able to receive our data from this system in the future. Another major change is gathering the DDS data from the Electronic Records Express web site

which will increase the accuracy and speed of gathered records.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2011	matching data files	8.5	6.1	6.9

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

It is clear that the outcomes for women covered by Medicaid are poorer when compared to women in the general population in Utah. Through analysis of Utah PRAMS and birth certificate data, women enrolled in Medicaid during pregnancy have an array of risk factors that are also commonly identified at higher rates among women who have low birth weight babies. These risk factors include lower levels of education, low socio-economic status, being unmarried, using tobacco before and during pregnancy, and being of a racial or ethnic minority group. Programs work to improve pregnancy outcomes in general, identifying risk factors for low birth weight, issuing briefs on the impact of pre-pregnancy body weight on low birth weight and so on.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

Many risk factors are not amenable to Title V interventions, such as income and education, however those that are, e.g., tobacco use, are being addressed through ongoing collaborations with Medicaid and the Tobacco Prevention and Control Program and others to promote tobacco cessation strategies for pregnant women. We also work with partners to address other issues associated with low birth weight such as elective inductions, previous preterm birth, substance use, etc. Staff from Medicaid and the Maternal and the Infant Health Program are working together to educate women who enroll in Medicaid about the potential of preventing recurrent singleton preterm births with the early and continuous use of 17 alpha hydroxyprogesterone (17P).

c. Interpretation of what the data indicate:

Data indicate that women enrolled in Medicaid fare far worse than their non-Medicaid counterparts. The percentage of low birth weight births among Medicaid women was 8.5% in 2011 compared to 6.1% in women not enrolled in Medicaid. Utah's Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate that women enrolled in Prenatal Medicaid are more likely to have numerous risk factors which make them more likely to have a LBW infant, for example they are more likely to be younger, unmarried, have less than a high school education, be of a racial or ethnic minority group, and use tobacco during pregnancy. These factors may be contributing to higher rates of LBW among our Prenatal Medicaid population.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2011	matching data files	5.8	5.1	5.3

Narrative:
a.

The Utah Department of Health's Maternal and Infant Health Program (MIHP) has administered the Perinatal Mortality Review (PMR) Program since 1995. The program provides a forum in which infant deaths due to perinatal conditions are identified through vital records events. These cases are thoroughly reviewed by our PMR Coordinator, a Certified Nurse Midwife with many years of clinical experience, and presented to a committee of perinatal health care providers on a monthly basis. Case reviews result in recommendations from committee discussions being implemented, as possible, to prevent future infant deaths.

b.

The MCH Bureau continues work with a consortium of ten facilities in the state that self-designate as Level III NICUs. The purpose of this consortium is to build consensus on how facilities designate themselves for level of neonatal care with the goal of improving outcomes for VLBW. The consortium is also working towards the goal of sharing clinical data on these vulnerable infants.

In November 2012, the UDOH partnered with the March Of Dimes to hold a Prematurity Symposium. There were four goals for the symposium; Encourage collaboration for the prevention of preterm birth (PTB), raise awareness of the scope of the problem, identify specific characteristics and consequences associated with PTB, and identify the areas of focus and make recommendations for interventions. Day two of the symposium gathered key stakeholders to develop actionable recommendations for PTB reduction. It is hoped that by preventing preterm births, the infant mortality rate will decrease in tandem as the largest portion of infant deaths in Utah are attributable to perinatal conditions.

The Utah Chapter of the March of Dimes, the Utah Department of Health, the University of Utah Health Sciences Center, and Intermountain Healthcare are coordinating the formation of the Utah Women and Newborn Quality Collaborative (UWNQC) to improve perinatal and neonatal service quality in Utah. The UWNQC will be a statewide, multi-stakeholder network dedicated to improving perinatal outcomes in Utah.

c.

The rate of infant mortality for the nation as a whole was 6.1 infant deaths per 1,000 live births (2011). Utah compares favorably with a rate of 4.65 infant deaths per 1,000 live births (2011), one of the lowest infant mortality rates in the country. However, this rate was an increase from 2010. Women enrolled in Medicaid have a higher rate of infant mortality than the state as a whole (5.8/1000 live births, 2011. Again, we know that women enrolled in Prenatal Medicaid have numerous risk factors which make them more likely to experience an infant death, for example they are more likely to be younger, unmarried, have less than a high school education, or be of a racial or ethnic minority group. These factors may be contributing to higher rates of infant mortality among our Prenatal Medicaid population.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2011	matching data files	64.5	80.1	74.7

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

Eligibility for Utah Prenatal Medicaid is at the lowest allowable income level. Utah women's income must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Utah is one of only six states that require an asset test to qualify for Medicaid. Because of these policies, many working poor women who may be eligible in other states across the country are reduced to self pay for prenatal care affecting entry into prenatal care. We note a growing population of women who are not eligible for Prenatal Medicaid due to lack of eligibility or issues with citizenship status, which interferes with early prenatal care. Due to contractual issues, the Baby Your Baby media campaign that encourages women to get early and continuous prenatal care was suspended and no ads were run in 2012, but resumed in March 2013.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

The Maternal and Infant Health Program maintains a web-based application system for presumptive eligibility for prenatal Medicaid, called UtahClicks. We continue to add sites that receive prenatal presumptive eligibility applications around the state to expedite a pregnant woman's ability to enroll in the program and begin prenatal care before the end of the first trimester.

With implementation of the Affordable Care Act in 2014, the qualifying poverty level for Medicaid will be slightly higher and the asset test will no longer be required for eligibility. Not having the asset test will hopefully increase application processing time. The Maternal and Infant Health Program will work with Medicaid to educate pregnant women on changes occurring to eligibility requirements.

c. Interpretation of what the data indicate:

The overall entry into first trimester prenatal care for Utah pregnant women was 74.8%, however for Medicaid women, the rate was 64.5%. Utah falls short of the Healthy People 2020 goal for 77.9% of women entering prenatal care during the first trimester. We do however continue to have comparatively good pregnancy outcomes. While we continue to promote early and regular prenatal care in Utah through our Baby Your Baby program, we are now also placing emphasis on promoting preconception health among reproductive age women through our "Power Your Life" campaign.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2011	matching data files	76.9	89	84.9

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

See HSCI #04. Eligibility for Utah Medicaid prenatal services is the lowest allowable income level of income for enrollment. Utah women must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Utah is one of only six states that require an asset test to qualify for Medicaid. Because of this stipulation, many working poor women who may be eligible in most other states across the country are reduced to self pay for prenatal care affecting their entry into and adequacy of prenatal care. The growing population of individuals with citizenship issues due to federal restrictions on eligibility prevents a large number of women from early entry. Since there are a limited number of safety net providers to provide prenatal services to this needy population, it is difficult for these women to get any prenatal care. The Maternal and Infant Health Program contracts with the Salt Lake City Community Health Centers Inc. to provide prenatal services for unfunded pregnant women who reside within the city limits, but the funding is inadequate to cover the need. Due to contractual issues, the Baby Your Baby media campaign that encourages women to get early and continuous prenatal care was suspended and no ads were run in 2012.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

We continue to focus on several initiatives to continue to reduce the rate of women who receive inadequate prenatal care in Utah including: strategies to reduce the teen pregnancy rate and to engage safety net providers who will cover uninsured women and encourage them to receive early and adequate prenatal care services. The Utah Clicks online enrollment application system provides easy access for pregnant women to begin their presumptive eligibility process to enroll in prenatal Medicaid. In FY13, the Maternal and Infant Health Program returned oversight of presumptive eligibility to Medicaid. It is hoped that removing MCH as the "middle man" will improve program coordination and timeliness of applications. MCH staff hold quarterly coordination meetings with the Medicaid staff involved in oversight. In FY13, a new contract was secured to resume the Baby Your Baby media campaign. Remarketing of Baby Your Baby will include presences on Twitter, Pinterest and a Baby Your Baby Blog.

c. Interpretation of what the data indicate:

Women enrolled in prenatal Medicaid (76.9%) are significantly less likely than non-Medicaid (89.0%) women in Utah to have received adequate prenatal care based on the Kotelchuck index.

We know that Medicaid enrolled Utah women are also much more likely to have reported their pregnancies as unintended and as a result, less likely to have entered prenatal care in the first trimester. Late entry into prenatal care accounts for the majority of inadequate prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2012	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2012	200

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

Efforts to drop the required asset test for infant Medicaid has not been successful to date. In fact, the asset allowable level was dropped from $5000 to only $3000.

During the past five years, due to inadequate state funding, CHIP was not able to maintain open enrollment. However the state legislators have since appropriate additional state funds to allow CHIP to remain open for enrollment.

The 2007 Legislature allocated additional funding to Medicaid to cover the anticipated increase in eligible children due to the CHIP application process which starts with a determination of Medicaid eligibility. With the economic downturn, more children have been enrolled in both programs. Enrollment numbers have steadily increased.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

It is very difficult to impact these numbers due to the factors that influence enrollment. The Department works with its partners, community-based organizations and advocates to reach out to individuals who may possibly be eligible for either program.

c. Interpretation of what the data indicate:

This HSCI has been constant since the two programs were started in the state. Medicaid has an additional eligibility requirement imposed on applicants - an asset test. The required asset test prevents an individual with some resources (above $3000) from being determined to be eligible.

The state legislature controls the state funding that is required for both of these programs limiting the eligibility to their current levels.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2012	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2012	 200

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

See 6A

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

See 6A

c. Interpretation of what the data indicate:

See 6A.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2012	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2014
Pregnant women usually are not covered under UT CHIP unless they are <18 years old.

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

Advocates have garnered some support to get legislators willing to sponsor a bill to drop the required asset test. However, to date this effort has been unsuccessful.

b. What efforts are being made by the program in developing new strategies for meeting the

HSCI?

The Department works with its partners, community-based organizations and advocates to reach out to individuals who may be eligible for Medicaid prenatal. The Division of Family Health and Preparedness administers the Baby Your Baby Presumptive Eligibility (PE) Program to ensure access for potentially eligible women to apply for PE while waiting for determination of their Medicaid eligibility. With the implementation of UtahClicks, access to PE is easier and more convenient.

c. Interpretation of what the data indicate:

This HSCI has been constant since the Medicaid prenatal program was first implemented. Medicaid has an additional eligibility requirement imposed on applicants - an asset test. The asset test prevents an individual with some resources (more than $3000) from being determined to be eligible. The state legislature controls the state funding that is required for this program limiting the eligibility to their current levels. It is not likely that this HSCI will change unless the income eligibility changes at a later date.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
SAMHSA Prevention Needs Assessment (SHARP/PNA)	3	Yes

Notes - 2014

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCI?

Utah uses the Youth Risk Behavior Survey (YRBS) to monitor trends in youth tobacco use. In 2003, the YRBS was integrated into Utah's SHARP project, a larger biennial school survey that includes Utah's substance abuse survey overseen by the Division of Substance Abuse and Mental Health in Human Services. The Department of Health received a CDC grant to conduct the 2009 and 2011 YRBS because the funding requirements were changed to allow health departments to apply. Weighted results for the 2009 and the 2011 YRBS are available on the web-based Utah Department of Health Indicator-Based Information System for Public Health (IBIS). New YRBS data are being collected in Utah high schools in the spring of 2013.

b. What efforts are being made by the program in developing new strategies for meeting the HSCI?

The Department of Health, in collaboration with the State Office of Education and the Division of Substance Abuse and Mental Health, conducts the Youth Risk Behavioral Survey (YRBS) in Utah schools in the spring of odd years. Utah's YRBS methodology follows CDC's requirements. Since the combined school and student participation rate has been above 60% for all survey years, Utah has consistently received weighted YRBS data from the CDC. Utah will continue to administer the YRBS in collaboration with other state-sponsored school surveys to reduce survey cost, minimize the survey burden on schools, and to achieve adequate participation rates despite Utah's active parental consent requirement.

c. Interpretation of what the data indicate:

Utah continues to have low rates of tobacco use among high school students. The rate of current tobacco use was 7.8% in 2011. The cigarette smoking rate was 5.9% and this was the lowest rate recorded by YRBS. Any tobacco uses as well as the smoking rate have declined since 1999 which was 14.5% and 11.9% respectively.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The initial planning process for the FY2011 - 2015 needs assessment process included a review of the previous needs assessment processes of 2000 and 2005 as well as methodologies used by other states for their needs assessments. After review of a number of different processes, the leadership team decided to use some of our previous processes and to enhance the scope of information gathering from external stakeholders through different methods. We reviewed the past five -- ten years of data on Performance Measures, Outcome Measures, health status indicators, health systems capacity indicators, and gaps to identify strengths and challenges in meeting the needs of the MCH populations in Utah. We reviewed what has worked to enhance health and wellness and what hasn't. We will develop new strategies and programs to address the gaps and shortfalls after we submit the grant and have an opportunity to strategize how best to address the priorities.

The leadership team developed the five-year needs assessment plan that included enhancing the stakeholder survey for each of the MCH populations and health service or system issues that had been used in the previous needs assessment processes. The stakeholder survey was revised from the previous one to include more issues related to the health needs of mothers and children, including those who special health care needs. We also developed a parent survey to gather information from those with children or youth with special health care needs.

We sent the stakeholder survey to partners, individuals on advisory committees for their input. Parent contacts came from Family Voices, parents of children served through CSHCN clinics. Both surveys were designed for online response. The response numbers were impressive to us and have provided us with enough responses to feel we can use the input we received.

State Performance Measures were determined based on the priorities identified. For example, preterm births and folic acid were identified as a priority, so they became the State Performance Measures for the next five years.

For the FY10 reporting year, we achieved 12 out of 18 measures and did not achieve 6 measures. The measures that we fell short on included: immunizations, sealants, breastfeeding, suicide, prenatal care and very low birth weight births at Level III facilities. We will continue to work on these areas to promote improvement.

We have been putting a great deal of effort into the issue of VLBW infant births at tertiary centers. As noted elsewhere, we have been concerned about the increase in the number of hospitals in the state that are self-designating as Level III NICUs. In reviewing capacity in these hospitals, it is clear that they are not Level III, but market themselves as such. We are meeting with stakeholders to discuss how to address the issues related to this self-designation.

Another issue tied into this is the birth hospital for the mother. The focus generally is on the infant outcome, but if we do not provide the same level of care that a high-risk mother needs, we will continue to see babies with poor outcomes. We have to recognize that the hospital of birth relates not just to newborn care, but also maternal care. If the mother is delivered in a hospital with a NICU, but not staffed by a maternal fetal medicine specialist, we are doing both mother and infant a great disservice. We have to acknowledge that tertiary care relates to the mother and the infant.

The state priorities have been "assigned" to specific programs and staff. One of our programs includes the assigned performance measures to the staff member's performance plan. Every quarter, the staff reviews progress on the performance measure.

/2013/ For the 2011 reporting year, we accomplished 14 of the 18 National Performance Measures, and 4 of the 10 State Performance Measures. The National Performance Measures

that we did not meet include: NPM 3, 4, 5 which relate to coordinated care for CSHCN in a medical home, adequate insurance and community-based services. The fourth measure we did not meet was related to adequate immunizations for young children. The CSHCN Performance Measures that we did not accomplish may be related to, in part, to our ability to provide as many services as we have in the past due to significant budget cuts. The Immunization Performance Measure has been an ongoing challenge to meet.

The State Performance Measures that we did not meet include: multivitamin use prior to pregnancy, reduction in proportion of primary C/Sections among low risk women, depression in youth, dental service utilization for children ages 1 - 5, routine developmental screenings, and proportion of CSHCN in rural areas receiving direct clinical services. Obviously we need to continue our efforts to promote the importance of multivitamin use, routine developmental screenings and dental care for young children, as well as a reduction in C/Sections, addressing depression among our youth. The decrease in the proportion of CSHCN in rural areas receiving services from our programs is directly related to funding cuts that occurred due to a cut in clinics and clinical services to the rural areas. Unless we are able to regain the state general funds lost in the previous years, our ability to address the great needs in the rural areas for CSHCN will continue to be a challenge.

We will continue to address the measures that we have been successful in achieving, but will put forth more efforts for the measures that are not progressing as we would like. //2013//

/2014/ For the 2012 reporting year, we accomplished 15 of 18 National Performance Measures and 8 of the 10 State Performance Measures. The National Performance Measures that we did not meet include: deaths of children <14 due to MVC, children without insurance, and pregnant women smoking in the last trimester of pregnancy. MVC deaths for children under 14 years of age increased this past year which will be addressed by the Violence and Injury Prevention Program through its strategies to reduce these deaths. Children without insurance as reported in this application is reported based on Department data sources which is much lower than the percentage reported in national surveys. The explanation for this may be due to different ways of evaluating the measure, such as no insurance in the past 30 days, no insurance at any time this past year, etc. Of concern is the increasing proportion of children without insurance. Factors influencing insurance access are discussed in the State Overview section under Medicaid and CHIP. MCH staff have discussed the rising uninsured children rate with Medicaid and they are in the process of developing strategies to better facilitate children's access to Medicaid and CHIP. The eligibility process is the responsibility of another state agency which makes it difficult to impact agency practices. rising and Utah has established policies that restrict eligibility more than in other states. Smoking during the last trimester of pregnancy did not decline as projected by 0.1% of obejctive. We will continue to work with colleagues in the Tobacco program to address this issue.

The State Performance Measure that we did not meet include: developmental screening and CSHCN in rural communities receiving CSHCN services. The developmental screening measure was categorized as not met because we were only able to establish a baseline for this measure for this year's application. The disappointing reach to CSHCN in rural communities is due to the large cuts in state funding for these clinics. The Department submitted a request for additional ongoing funding to the Legislature, but it was not approved. We plan to resubmit the request for the 2014 Governor's budget. //2014//

B. State Priorities

The Needs Assessment Leadership Team met to review the information we received from the surveys we conducted to determine which ten priorities we were going to focus on for the upcoming 5 years. We decided on the following priorities based on impact to population, numbers impacted and ability to address. For an in-depth discussion of State Priorities, please refer to the

Five Year Needs Assessment documents.

For Mothers and Infants
-Prevention of preterm births
-Reduction in C/Sections for low risk pregnant women
-Neural tube defects prevention

Children and Youth
-Early childhood developmental screening
-Access to oral health for young children -- birth to 5
-Reduction in obesity among children/ physical activity
-Reduction in tobacco use among youth- we selected this measure as a proxy for substance abuse
-Improved access to mental health services

CYSHCN
-Reduction in out of pocket expenses for health care for families with children or youth with special health care needs
-Services for children and youth with special health care needs in rural areas

The needs assessment process included a review of status on National and State Performance and Outcome Measures, as well as Health Status, Health Systems Capacity Indicators and health care systems in the state. This review assisted in identifying priority areas along with the top issues obtained from the key informant survey.

The Leadership Team decided not to include in the list of priority issues any issue that was already addressed in a National Performance Measure so that we could specifically focus on other areas of need. Some of the State Performance Measures from the 2006 Needs Assessment have been dropped because of coverage provided through health care reform, higher priorities to address, difficulty in measuring a state Performance Measure. We decided to put emphasis on late preterm births, most of which are preventable, health concerns for children and adolescents, and coverage and services for children with special health care needs.

The Division will continue to explore information related to the state priorities to assist us in planning methods to address the specific issues. The state Title V agency will develop specific plans to address the ten priorities through input from partners and others.

Recognizing that the needs assessment is an ongoing process, Title V leadership will continue to monitor Utah's progress in the priority areas identified in the needs assessment process, including those that were not included in the final list. Each year as additional data become available, such as adequacy of prenatal care statistics, programs review the data and seek strategies to address the findings. We will continue to review data as it is available to assess needs of mother, infants, young children, school-aged children and youth, including those with special health care needs as we implement the plans for the coming five years.

/2013/ The Utah Department of Health has identified "Healthy Utah Babies" as a priority to include in its strategic plan. The staff working on "Healthy Births" plans to initiate an effort to be called "Healthy Utah Babies" (HUB) that will cover preconception through pregnancy, postpartum and interconception for women and cover infancy to young childhood to age 5 years. We viewed this priority of the Department as an opportunity to enhance work already being done in MCH/CSHCN programs and to provide the impetus to expand our efforts to promote the importance of key periods of life course for women of child bearing ages and key periods of life course for infants through early childhood.

The Department signed on to the ASTHO/MOD commitment to reduce prematurity by 8% by 2014, another effort that will contribute to the work on HUB. We are working with the March of

Dimes on their efforts to reduce prematurity. We see this as an opportunity to address areas of great concern with multiple partners at the table working towards the same goal. The March of Dimes is sponsoring a Prematurity Summit in November 2012 in which the Department will play a key role. From this Summit will come an action plan in which public health will have a key role.

These efforts address the three priorities for mothers and infants and several of the priorities for children. The Department's Strategic Plan for healthy births affords us the opportunity to work with staff from all areas within the Department, especially the chronic disease programs. Through this work, we will bring forth the importance of a life course perspective as it relates to an number of different areas that really need to be addressed through a life course perspective if we are to have an impact on the health outcomes.

Other areas that we are working on include: 1) promoting awareness of risk of recurrent preterm birth and promotion of possible interventions to reduce risk; 2) addressing factors that may contribute to poor pregnancy outcomes, such as weight before pregnancy and after, healthy weight gain during pregnancy, 3) developing criteria for NICU Levels of Care and developing a rule for hospital reporting; and 4) developing a report on prematurity in Utah.

For future work, we plan to address the following issues related to healthy births: Chronic Disease in Women, Obesity, Smoking and Substance Abuse, Mental Health, Family Violence, Infertility, Multiple Births, Hearing Loss, Metabolic Disorders, Oral Health, Health Disparities, Health Insurance, Preconception Health and Medical Home in no particular order. //2013//

/2014/ We currently are working on a number of strategies to address Healthy Utah Babies (HUB) as part of the Department's strategic plan. The workgroup has divided into several sub-committees: Preconception with a focus on health before pregnancy and between pregnancies, Infants with a focus on promotion of breast feeding and young chidlren with a focus on early childhood developmental screening.

The Breastfeeding workgroup has developed a survey of all birthing facilities to gather information on the status of efforts to move toward meeting the 10 steps that are recommended to be classified as a Baby Friendly Hospital. Almost all birthing hospitals responded. The responses were encouraging in that 4 hospitals inidcated that they are in the process of becoming Baby Friendly. Many responders indicated they would like to be involved in a collaborative effort with UDOH to help more facilities move in this direction.

Early Childhood Developmental Screening has entailed a survey of pediatricians and other providers on their practice of developmental screening, including tools used, is it done routinely, etc. Preliminary review of responses indicates that most pediatricians use a formal tool to screen for developmental delays and most also were aware of the AAP recommendations on developmental screening. //2014//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	463	423	417	417	322
Denominator	463	423	417	417	322

Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	100	100	100	100	100

Notes - 2012
Utah Newborn Screening Program Database 2011 Data

Notes - 2011
Data reported are the most recent data available.
Utah Newborn Screening Program Database 2010 Data

Notes - 2010
Data reported are the most recent data available.
Utah Newborn Screening Program Database 2010 Data

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 100% and the Annual Indicator was 100%.

The Utah Newborn Screening Program (NSP) continued surveillance and identification of children with congenital hypothyroidism, galactosemia, biotinidase deficiency, congenital adrenal hyperplasia, amino acid disorders, organic acid disorders, fatty acid disorders, hemoglobinopathies and cystic fibrosis. NSP collaborated with the University of Utah (U of U) Metabolic Clinic, ARUP Laboratories, Ambry Genetics and the Utah Department of Health State Laboratory (UDOH Lab) to provide testing for disorders and follow up.

All newborns requiring testing beyond the newborn screening panel were referred to medical homes and subspecialists as needed. If a family had moved out of state or the baby was adopted by a family out of state, every attempt was made to locate the family and medical home as well as to notify the newborn screening personnel in that state. Final diagnosis was requested and confirmed by either the medical home or the subspecialist. Diagnostic forms for collection of this information were sent and receipt tracked. A case was closed only upon receipt of the diagnostic form.

Newborn screening education was provided to hospitals, medical homes, other medical providers, families and the general public. Additionally, the Bureau of Children with Special Health Care Needs (CSHCN) continues to provide financial assistance for medical food for families and individuals with PKU.

The Genetic Advisory Committee Newborn Screening (GAC NBS) subcommittee met on a quarterly basis to explore the addition of Severe Combined Immunodeficiency (SCID) to Utah's newborn screening panel. NSP and the Utah Birth Defects Network (UBDN) applied grant funding to evaluate Critical Congenital Heart Disease (CCHD) pulse oximetry screening at high altitude and develop a statewide implementation plan as part of newborn screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Abnormal screening results, if appropriate, were reported to the newborn's medical home.		X		
2. Newborns needing confirmatory testing were referred to sub-specialists, as needed, and tracked to final outcome (normal or disorder identified).		X		
3. The addition of SCID to Utah's newborn screening panel was explored.			X	
4. A grant application submitted to evaluate pulse oximetry screening for CCHD at elevation.				X
5. Education was provided to hospitals, medical homes, other medical providers, families and the general public.				X
6. Financial assistance for medical food was provided to families and individuals with PKU.		X		
7.				
8.				
9.				
10.				

b. Current Activities

NSP continues surveillance, identification, care coordination and tracking of children with an abnormal screen results. Collaboration continues with the U of U Metabolic Clinic, ARUP Laboratories, Ambry Genetics and the UDOH Lab to provide testing for disorders and follow up. The GAC NBS subcommittee continues to meet on a quarterly basis and is recommending the addition of SCID to Utah's newborn screening panel.

NSP and the UBDN are receiving grant funding to evaluate CCHD pulse oximetry screening at high altitude and develop a statewide implementation plan as part of newborn screening. NSP and the Lab are upgrading the Laboratory Information Management System (LIMS). LIMS is an integral part of tracking and transmitting newborn screening results.

NSP continues to provide a monthly quality assurance report cards for hospitals. NSP is working with the Lab Sample Receiving Department to improve the process of logging in newborn screening samples.

NSP continues involvement with the cHIE and CHARM projects to integrate data for newborn screening, newborn hearing, immunization and vital records. NSP continues to support and facilitate the 'Medical Home' model of health care. A NSP monthly newsletter is being sent to partners and providers. NSP is working with UBDN on its National Birth Defects Prevention Study project. Newborn hearing and NSP are collaborating to provide education and assistance with the Home Visiting, Neonatal Follow-up, and Fostering Healthy Children programs.

c. Plan for the Coming Year

NSP will continue surveillance and identification of children with congenital hypothyroidism, galactosemia, hemoglobinopathies, biotinidase deficiency, congenital adrenal hyperplasia, cystic fibrosis, amino acid disorders and acylcarnitine disorders. Care coordination and data tracking will be ongoing. Collaboration will continue with the U of U Metabolic Clinic, ARUP Laboratories and the UDOH Lab to provide testing for disorders and follow-up.

NSP and the UDOH Lab plan to complete a LIMS upgrade. NSP will work with the UDOH Lab

and ARUP to validate the SCID screen, develop a testing algorithm and implement newborn screening for SCID in 2013. In addition to a kit fee increase, NSP is researching alternatives to offset the costs of screening for SCID.

The NSP will work with the UBDN on the CCHD newborn screening grant to evaluate pulse oximetry screening at high altitude as part of newborn screening. The NSP will work with hospitals to prepare for implementation of CCHD pulse oximetry newborn screening as part of a state legislative mandate in 2014.

NSP plans to utilize CSHCN's updated telehealth facilities to improve access to heelstick training for birth hospital staff and medical homes throughout Utah with an emphasis on rural areas.

The QA Report Cards for hospitals will continue with the emphasis on decreasing unsatisfactory specimens, incomplete data on cards and improving timeliness of specimen receipt at the UDOH Lab.

The NSP will assist with educating providers on accessing newborn screening results through the cHIE/CHARM website and explore disseminating newborn screening information and education via social media.

Newborn screening kits will be sold to all institutions of birth and to direct entry midwives. Consultations with all providers will be available by phone or site visit. Consultations and education of families and the general public will continue. The NSP will work with its lab partners to review the screening processes and test results to reduce the false positive rates and improve the overall quality of our services.

Collaborative and financial support to the Uof U Metabolic Follow-up Clinic, which follows children with PKU and galactosemia, will continue. NSP will work with families, the Utah Insurance Department, Medicaid, and private insurance companies to facilitate the billing and coding systems.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**52288**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	51887	99.2	8	3	3	100.0
Congenital Hypothyroidism	51887	99.2	28	23	23	100.0

(Classical)						
Galactosemia (Classical)	51887	99.2	6	1	1	100.0
Sickle Cell Disease	51887	99.2	241	0	0	
Congenital Adrenal Hyperplasia	51887	99.2	13	6	6	100.0
Hearing Screening	51661	98.8	575	104	87	83.7
Biotinidase	51887	99.2	2	2	2	100.0
Acylcarnitine Disorders*	51887	99.2	72	18	18	100.0
Galactosemia (non-classical)	51887	99.2	6	4	4	100.0
Hemoglobinopathies (non-sickle cell disease)	51887	99.2	241	237	237	100.0
Amino Acid Disorders **	51887	99.2	25	13	13	100.0
Cystic Fibrosis***	51887	99.2	21	18	18	100.0
Diet Monitoring, 0-18 yrs ****	884		87	87	87	100.0
Diet Monitoring Pregnant Women *****	31		2	2	2	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	52	55.1	55.1	55.1	71.5
Annual Indicator	55.1	55.1	55.1	71.5	71.5
Numerator					
Denominator					
Data Source	See footnote for source	See footnote for source	See footnote for source	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	71.5	71.5	71.5	71.5	71.5

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first

conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 55.1% and the indicator was 71.5%.

Family leadership trainings were provided to new and existing Parent and Family Partners in the various Medical Home projects in the state. Training has consisted of resiliency, boundaries, privacy and confidentiality and care of the caregiver to name a few. The CSHCN Utah Family Voices (UFV) Director presented at a Learning Session and various webinars to pediatric clinics about the perspectives of families in the mental health system as well as resources for the unique needs of the families and their communities.

Parents involved in Medical Homes have been innovative in providing support to the families in their respective clinics that included a professional informational panel on parent-driven topics such as seizures, fundraising events to help with unfunded critical needs identified by the clinic, social media platforms that facilitated the networking between families, and the development and continual updating of a community based resource guide. Some parent partners were utilized to collaborate on the development of family friendly policies, implementation of quality improvement projects and evaluation of outcomes from a family's perspective.

The CSHCN UFV Director and the Family to Family Health Information Center (F2F) staff provided the ABCs of Autism training into 12 additional communities throughout the state with collaboration and funding from a grant provided by Utah State University. Trainings were provided in a format that met the needs of the individual communities that included a Spanish curriculum, full day sessions for rural communities and shorter sessions for families in the urban area.

Compensation for family trainees and consumers and families involved in weekly didactic seminars in the Utah Regional LEND (URLEND) program was sustained and will continue as a high priority for the future academic years. The F2F staff provides monthly in-person training

about the day in the life of a family to the 2nd year medical residents and URLEND multidiscipline trainees.

Family-driven and family involvement in autism initiatives included the Autism Council of Utah which is a council made up of families, professionals and agencies that have a stake in children and youth with autism. The council provides awareness about autism, resources including a recent release of an application for both IPhones and Androids. The Utah Autism Initiative was set up by the former Utah Department of Health Executive Director to develop an interagency approach to work and collaboration on identified issues such as treatments available in the community and how to effectively evaluate their potential effectiveness or risk. The committee was also charged with addressing the communication and relationship between primary health care and the education system to effectively inform each of the systems on laws, myths and misunderstanding of families.

Family involvement at Primary Children's Medical Center increased as families were recruited for the Family Advisory Council. The F2F staff all participated and served terms on the Council providing perspectives from a family. One of the staff members was eventually recruited to become the first "family" member of the PCMC Board of Trustees.

The CSHCN FV Director was nominated and awarded the Utah Chapter of the American Academy of Pediatrics Child Health Advocate Award for the work done on behalf of Medical Homes, Family Centered Care and Parent Involvement. The UFV Director also was appointed as a "Family" representative to the National Institute for Child Health Quality (NICHQ) Board of Directors. The appointment provides a voice for families of children with special health care needs as well as a representative for quality improvement in children's health from a western rural state perspective.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Family involvement and leadership activities were imbedded into pediatric and sub-specialty clinics.		X		
2. Trainings were provided from an ABCs of Autism curriculum throughout the state.				X
3. Parents involved in training professionals on the concepts of family-centered care from the family's perspective were compensated for their expertise and involvement.				X
4. Family involvement and leadership in autism have led to innovative projects and products.				X
5. Primary Children’s Medical Center is modeling family/professional partnerships at all levels of the system.				X
6. Family Involvement and Leadership are being recognized by professional organizations.				X
7.				
8.				
9.				
10.				

b. Current Activities

The caregiver educational series that was developed for families of children diagnosed with an Autism Spectrum Disorder (ASD) is continually being expanded to benefit families of children with other disabilities and chronic health conditions based on feedback and input from families by the Family to Family Health Information Center (F2F).

The Utah Parent Center (UPC) is continuing its efforts of providing autism information through a toll-free phone line and up-to-date resources and a fact sheet for families of children with an ASD with the assistance of a small contract from the CSHCN Bureau. This information is especially critical due to data that show that Utah is the state with the highest rate of autism in the nation.

The CSHCN UFV Director is actively involved in a Leadership committee addressing issues related to Medicaid reform, and implementation of the Affordable Care Act as it relates to families of children with special health care needs and young adults with disabilities transitioning into adulthood and services.

Families are involved and participating in the Early Childhood (ECU) Utah State Advisory Committee and the Part C Early Intervention Interagency Coordination Council (ICC). These families are providing input and offering diverse opinions and perspectives from the grassroots level. The CSHCN UFV Director participates and is a member of the Medical Home subcommittee of the ECU and the Baby Find subcommittee of the ICC.

c. Plan for the Coming Year

The CSHCN UFV Director was accepted as a fellow in the Maternal and Child Health Public Health Leadership Institute which will begin as Cohort 4 in May 2013 to be finished in May 2014. The activities and leadership development will be utilized by the UFV Director to further family involvement and family leadership resulting in enhanced family satisfaction in the community-based system of care and ultimately better outcomes for children and youth with special health care needs.

Mental health and behavioral health continue to surface as high priorities and unmet needs due to many factors. Integrating physical health care with mental health care and emotional wellness is an emerging collaborative model that family engagement and family-riven care need to be included as a standard of care. The F2F will collaborate with the Utah Parent Center in their work with the Department of Human Services, Division of Substance Abuse and Mental Health along with Utah's Federation of Families grantee, Allies with Families, in developing a model of collaboration and initiatives that meet the needs of the whole family including educational supports, health care supports, mental health supports and peer-to-peer support from a seamless family support system.

Through some technical assistance support application from MCHB, CSHCN will propose to work with the Colorado Title V agency to bring an expert trainer to Utah on Family Leadership development. The trainer is nationally known as providing Causal Leadership and motivational speaking from the expertise of a parent of a young adult with disabilities. The trainer is state Title V staff and is involved with the National Family Voices organization. Families from many different organizations and programs throughout the state will be invited to the training to promote additional and an expanded level of family involvement throughout the state to effect positive systems of change for children and youth with special health care needs.

As the Affordable Care Act is further implemented the CSHCN UFV Director will investigate opportunities for families to be involved in the Navigator and Consumer Health Assistance initiative to be experts on the unique needs of families searching for health care financing for children and youth with special health care needs. Collaboration with the Federally Qualified Health Centers and other interested community based advocacy groups will be key to successful planning and potential funding for services to the F2F.

Available funding from the CSHCN Bureau will be secured to help sustain the F2F staff in providing peer support and resource navigation to families across the state as well as family

involvement and consultation in MCH including CSHCN clinics and programs.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	49	52.2	52.2	52.2	46.2
Annual Indicator	52.2	52.2	52.2	46.2	46.2
Numerator					
Denominator					
Data Source	See footnote for source	See footnote for source	See footnote for source	See footnote	Seefootnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	46.2	46.2	46.2	46.2	46.2

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The Performance Measure was achieved. The performance objective was 46.2% and the Annual Indicator was 46.2%.

The 2009/10 National Survey of Children with Special Health Care Needs indicated a 6% decrease in the percentage of children with special health care needs who receive care within a medical home from the previous survey in 2005/6. The Survey also indicated an almost 2% increase in children with special health care needs without insurance, almost 4% increase in children with special health care needs with inadequate insurance, and almost 7% increase in children with special health care needs without a usual source of care when sick (or who rely on the emergency room). It is possible that the economic downturn affecting Utah and the nation impacted the number of children with insurance thereby impacting the number of children with special health care needs without a medical home. It is possible that NPM-3 will not see a significant increase until Utah has seen a significant, sustained economic recovery.

The Medical Home Program and the Bureau of Children with Special Health Care Needs (CSHCN) utilized the CSHCN Executive Group (CEG) and its consultant group to gather feedback from stakeholders at the quarterly meetings. The CEG consisted of CSHCN administration and program managers with key consultants. The CEG consultants consisted of representatives of selected community partners including the University of Utah Department of Pediatrics, Utah State University Center for Persons with Disabilities, Utah Family Voices, State Office of Education, Utah School Nurse Association, Utah Parent Center, and other partners.

In an effort to promote a coordinated services system, CSHCN partnered with various groups. CSHCN partnered with the Medical Home Portal staff at the University of Utah to provide quarterly Medical Home Corner articles for the Growing Times, the newsletter of the Utah Chapter of the American Academy of Pediatrics. The two groups also collaborated to provide quarterly Your Medical Home articles for the Medical Home Portal newsletter. The Medical Home Portal team continued to develop new content and add new resources to the website and continued negotiations to include other states' lists of community services.

In other efforts to improve the system of services, the Medical Home Program staff served on a variety of interagency committees, including the Steering Committee of the Interagency Outreach Training Initiative (IOTI). The IOTI provided state-funded grants for training to increase capacity of organizations to serve people with disabilities and their families. Staff also participated on the Utah Oral Health Coalition, Utah Fetal Alcohol Coalition, Employment Partnership, and others.

Collaboration continued among Family Voices, Utah State University, University of Utah, and Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) regarding CSHCN projects, medical and nursing school curricula, and the Medical Home Portal. Medical students met with Utah Family Voices Staff to gain a perspective from families with CSHCN. URLEND trainees provided consultation to the practices involved in the CSHCN medical home trainings along with families of CSHCN.

The University of Utah's Pediatric Partnership to Improve Healthcare Quality (UPIQ) is involved with the Children's Health Insurance Program Reauthorization Act (CHIPRA) grant to help improve medical homes and the quality of health care for children in Utah and Idaho. Efforts

include supporting care coordinators, improving content and resources for families and providers on the Medical Home Portal website, and a variety of other activities. The Medical Home Program staff provides consultation to the Medical Home Portal team regarding potential and planned improvements to better serve CSHCN, their families, and their providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Medical Home Program partnered with the Medical Home Portal to provide quarterly articles for the Utah Chapter of the American Academy of Pediatrics' newsletter.				X
2. Medical Home Program staff developed Work Sheet newsletters for the Employment Partnership workgroup to support youth transitioning to adulthood.		X		
3. Medical Home Program staff participated as a member of the Interagency Outreach Training Initiative to provide training grants to improve services for people with disabilities.				X
4. Families and professionals helped improve content on the Medical Home Portal website, www.medicalhomeportal.org.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Medical Home Program is involved with efforts to increase developmental screening and improve the system of services for young children. The Medical Home Program is collaborating with the Family Involvement and Leadership Program, Medical Director, Bureau of Child Development, and staff from other programs to help providers expand the use of standardized screening tools and to help parents and providers understand the need for developmental screening.

The Medical Home Program is represented on committees and boards to improve the coordination of services and the provision of family-centered care. Staff serves on the Interagency Outreach Training Initiative Committee, Oral Health Coalition, and other interagency committees. The Medical Home Portal staff replaced the transition specialist on the Employment Partnership workgroup to develop the Work Sheet newsletters with highlights from the meetings for members and interested community organizations.

Outreach efforts include dissemination of medical home topic-oriented articles to pediatricians, through the Utah Chapter of the American Academy of Pediatrics and posting on the Medical Home Portal, www.medicalhomeportal.org. The Portal team continues to develop new content and add new resources to the website. The Medical Home Portal is working with New Mexico to import services from their 211 Information Resource and Referral agency at the University of New Mexico. Idaho services are displayed on the Portal also.

c. Plan for the Coming Year

The Medical Home program will provide in-office trainings as requested on medical home basics for medical practices. Support will be provided for previously-trained medical and dental homes

through problem solving upon request, sharing of resources and new opportunities, and development of news articles.

The Medical Home Program will provide "Learn the Signs. Act Early" campaign materials and support the website, Facebook and Twitter pages to help parents learn about healthy development, understand the signs of possible developmental delays, and encourage parents to access existing services if they suspect a problem.

The Medical Home Program will partner with the Medical Home Portal team to develop quarterly articles for the Utah Chapter of the American Academy of Pediatrics newsletter. The Medical Home Portal team will develop content related to genetic and chronic conditions to help medical homes provide care for children and youth with special health care needs. Outreach to families will continue through participation at community events.

The Medical Home Program will be represented on committees and boards to improve the coordination of services and the provision of family-centered care. Staff will serve on the Interagency Outreach Training Initiative Committee, the Employment Partnership workgroup, the Utah Fetal Alcohol Coalition, the Utah Oral Health Coalition, the Early Childhood Utah committee, the Mountain States Genetics Regional Collaborative, and other interagency committees. Collaborative efforts to support improved transition services in Medical Homes and to provide resources for young adults as they transition to adulthood will continue with the Medical Home Program and the Bureau of Children with Special Health Care Needs (CSHCN) Transition Specialist.

CSHCN will continue to seek input on activities and strategic plans from community partners. Key community partners include Utah State University, the University of Utah, Utah Family Voices, the Utah School Nurse Association, and other organizations serving families with CSHCN.

CSHCN will continue to support the URLEND in an effort to improve providers' understanding of the service system and chronic conditions of children with special health care needs.

The University of Utah's Pediatric Partnership to Improve Healthcare Quality (UPIQ) will continue to be involved with the Children's Health Insurance Program Reauthorization Act (CHIPRA) grant to help improve medical homes and the quality of health care for children in Utah and Idaho. Efforts will include supporting care coordinators, improving content and resources for families and providers on the Medical Home Portal website, and a variety of other activities. The Medical Home Program staff will provide consultation to the Medical Home Portal team regarding potential and planned improvements to better serve CSHCN, their families, and their providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	59	59.5	59.5	59.5	55.9
Annual Indicator	59.5	59.5	59.5	55.9	55.9
Numerator					
Denominator					
Data Source	See footnote for source	See footnote for source	See footnote for source	See footnote	See footnote

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	55.9	55.9	55.9	55.9	56

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 55.9% and the Annual Indicator was 55.9%.

The financing of health care services for children and youth with special health care needs continued to be an area of focus. Outreach efforts were conducted through statewide urban and rural clinic sites, health education activities, media and web sites to identify children and families who may be eligible for funding of health services through Utah Medicaid or CHIP. Providing information to families was a major component of the outreach process and included providing eligibility and application information on Medicaid, CHIP and other programs.

Care coordinators, family partners and clinical staff assisted families in working with their private insurances, Medicaid and Medicaid contracted HMO providers to access needed health-related services. Other resources such as charitable organizations and foundations were contacted to assist families with needed items and services not available under traditional insurance or Medicaid. Utah's Family-to-Family Health Information Center worked one-on-one with families giving them the information and tools needed to tap into a variety of resources and programs to

help meet their needs. Primary Children's Medical Center continued its agreement to write-off service charges for children who qualify for CSHCN (up to 133% of poverty) services and do not have any other payer source.

CSHCN conducted Medicaid administrative case management activities including outreach, information and referral, service coordination, evaluation and monitoring activities to ensure EPSDT-eligible children receive timely and appropriate access to needed Medicaid services. Case managers performed the day-to-day administrative activities for Medicaid's Technology Dependent Waiver Program which provides access to state plan Medicaid benefits and additional waiver services to help meet the needs of technology dependent/medically fragile children and their families.

Medicaid outreach projects during FY12 included identifying SSI-eligible children who were not enrolled in Medicaid and providing their families with information on how to apply for Medicaid and utilizing care coordinators and Utah Family Voices consultants in Medical Homes to disseminate application information and education about Medicaid and CHIP benefits.

The Division's medical director and physical therapist continued their participation on the EPSDT Expanded Services and Prior Authorization Committee for Medicaid reviewing documentation and providing recommendations on authorization of requested Medicaid services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach efforts were conducted statewide to identify children and families that may be eligible for public funding of health services.		X		
2. Information was provided to families including eligibility and application information on Medicaid, CHIP and other programs.		X		
3. Staff support was provided to families in working with their private insurances, Medicaid and Medicaid contracted HMO providers to access needed health-related services.		X		
4. Medicaid administrative case management activities were provided to ensure EPSDT -eligible children received timely and appropriate access to needed Medicaid services.		X		
5. CSHCN participated on the EPSDT Expanded Services and Prior Authorization Committee for Medicaid reviewing documentation and providing recommendations on authorization of requested Medicaid services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Outreach activities to bring new families into Medicaid and CHIP are being conducted statewide to identify children who may qualify for funding of health care. Strategies to reach potential children include evaluating eligibility during itinerant clinics, providing on-line information and application systems, identifying SSI-eligible children who are not yet enrolled in Medicaid, and utilizing parent partners in Medical Homes. Care coordinators, family partners and clinical staff in Medical Homes assist families to navigate the health care payer system and work with private health plans, Medicaid and Medicaid Accountable Care Organizations to access needed services.

Utah's Family-to-Family Health Information Center is responding to the needs of families with information on public and private health insurance including changes as a result of the Affordable Care Act.

CSHCN is providing the administration and authorization of services for Medicaid's Technology Dependent Waiver and assisting Medicaid with utilization review for their EPSDT Expanded Services and Prior Authorization Committee.

Three autism treatment pilots were implemented to cover behavioral services for a limited number of children between the ages of 2-6. The pilots include a Medicaid waiver, an autism treatment fund administered by CSHCN and benefits through the Public Employees Health Plan. There was an attempt through legislation for an insurance mandate to cover autism treatment which was unsuccessful.

c. Plan for the Coming Year

Financing health services will continue to be a priority in meeting the needs of children and families with special health care needs. Outreach efforts to identify children, especially minority and underserved populations, who may be eligible for funding of health care will be a component of each CSHCN program. Educating families by providing culturally relevant and linguistically appropriate information on available programs, eligibility requirements and application processes will occur during statewide clinics, through case managers, care coordinators and family partners, Medical Homes, web sites, and Utah Family Voices Family-to-Family Health Information. A database will be updated and maintained to identify SSI-eligible children not yet enrolled in Medicaid. Letters will be sent out in English and Spanish informing families of their potential eligibility and how to apply.

CSHCN case managers and clinical staff will help families work with private health insurances, Medicaid and Medicaid Accountable Care Organizations to access needed health-related services. Staff will conduct Medicaid administrative case management activities including outreach, information and referral, service coordination, evaluation and monitoring activities to ensure EPSDT-eligible children receive timely and appropriate access to needed Medicaid-covered services. Case managers will provide the day-to-day administration for Medicaid's Technology Dependent Waiver program and CSHCN will continue membership on the EPSDT Expanded Services and Prior Authorization Committee reviewing documentation and providing recommendations on service coverage.

CSHCN will work with Medicaid and state partners to administer and evaluate the pilot program for autism spectrum services which focuses on identification, payment for services and evaluation of the effectiveness of behavioral treatment.

Utah's Family-to-Family Health Information Center will respond to the needs of families through direct family-to-family support and information on public and private health insurance. Applications for grant funding will be sought and used to educate families on the impact of the Accountable Care Act and navigating the health care system. CSHCN will continue to monitor the expansion of options for private insurance coverage through Utah's health insurance exchange, Avenue H, which received conditional approval during this past state legislative session and possible expansion of Medicaid under the Accountable Care Act.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82	86.2	86.2	86.2	62.2
Annual Indicator	86.2	86.2	86.2	62.2	62.2
Numerator					
Denominator					
Data Source	See footnote for source	See footnote for source	See footnote for source	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	62.2	62.2	62.2	62.2	62.2

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 62.2% and the Annual Indicator was 62.2%.

Children with Special Health Care Needs (CSHCN) Bureau faced major funding challenges due to increased specialty provider contract fees and flat State and Federal funding. Even so, CSHCN staff worked closely with the Utah Medical Home Program, University of Utah (UofU) health care providers and Utah Family Voices on efforts to enhance access, collaboration, and efficient and effective clinical services and care coordination among community agencies, health care providers and families. CSHCN and UofU Pediatrics continued a more comprehensive collaboration during this period to increase the availability of their specialty consultations. The Bureau collaborated with Emergency Medical Services for Children (EMS-C) registry for children and youth with special health care needs (CYSHCN) to facilitate dissemination of information and access to the registry for patients in CSHCN clinics Statewide.

CSHCN continued to provide access to community-based specialty care through statewide satellite case management and traveling clinics. Specialists travel to the rural areas in Utah to provide evaluations, diagnostic services, transition support and follow-up. Specialty areas included the following: developmental pediatrics, psychology, speech pathology, genetics, neurology, occupational/physical therapy, audiology, orthopedic, cranio-facial and transition services.

CSHCN provided case management to high-risk populations including children dependent on technology in Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). FHC assisted foster families to coordinate community care and collected and documented medical information for approximately 4200 children in the foster care system. FHC worked with Utah Medicaid to improve Health Status Outcome Measures for children.

Other CSHCN Bureau programs augmented community clinical services, case management and capacity building efforts to enhance a coordinated system of care. The Newborn Follow-up Program (NFP) continued to provide assessment and developmental follow-up at selected sites around the State, for approximately 1700 children leaving Utah newborn intensive care units who met program criteria. CSHCN worked with the Department's Office of Health Disparities Reduction and Indian Health Service to improve access and collaboration with community providers of health, education, vocational rehabilitation, and health care coverage for populations served by those agencies.

Continued CSHCN collaboration with UHIN, CHARM, CHIE and other like entities focused on developing and implementing greater data sharing capabilities for agencies and health care providers of children with special needs. The Bureau selected and implemented the use of an electronic health records (EHR) system, CaduRx, enhancing efficiency in care coordination, billing and meeting future Federal mandates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN collaborated with Utah Medical Home Program and University of Utah health care systems to enhance access and coordination of services.				X
2. Continued use of referral forms and processes initiated statewide to facilitate access to and coordination of services, along with completed updates and maintenance of the Bureau website for ease of use.		X		
3. Utah's Family Voices and the Family-to-Family Health		X		

Information and Education Center provided parent-to-parent support and information on community resources and services.				
4. CSHCN provided access to community-based specialty care through statewide satellite case management and traveling clinics.	X			
5. CSHCN provided case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC).		X		
6. Neonatal Follow-up Program continued provision of clinical diagnostic, assessment and follow-up for NICU graduates meeting program criteria.		X		
7. CSHCN selected and implemented the use of a new EHR system, CaduRx and began preparation to attest for Meaningful Use over the next year.				X
8.				
9.				
10.				

b. Current Activities

In the face of flat State and Federal funding and increased provider contract fees, Children with Special Health Care Needs has had to reassess the allocation of resources to meet the needs of the Special Needs community in the State. CSHCN continues to provide access to community-based specialty care, transition services and coordination through statewide satellite case management and traveling clinics. CSHCN continues to provide case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). Bureau programs will continue to evaluate the service delivery system to increase efficiency, and assess for needed changes in case management. and clinical services. CSHCN continues work with EMS-C to facilitate access to their registry. The Bureau has entered into a joint project to provide access to dental hygiene and education for special needs children seen in our rural clinics.

The Newborn Follow-up Program (NFP) continues to provide multidisciplinary clinics to NICU graduates and will collaborate in University research projects for this population. NFP is in the process of linking its clinical database with the CaduRx EHR system.

CSHCN is implementing the use of the new CaduRx EHR system in CSHCN clinics, and currently focusing on Meaningful Use requirements and attestation for providers using the new system.

c. Plan for the Coming Year

On-going flat State funding and pending Federal funding reductions for CSHCN clinics will prompt the Bureau to do a complete review and evaluation of the clinic service delivery system, to increase efficiency, possibly combining or eliminating clinics or specific services as needed. CSHCN will continue its collaboration with University of Utah providers in order to facilitate ongoing provision of multidisciplinary specialty clinics in Salt Lake City and rural areas.

CSHCN will provide access to community-based specialty care and transition services through statewide satellite case management and traveling clinics. Specialists will travel to the rural areas in Utah to provide diagnostic, transition, care coordination services and follow-up. CSHCN will provide case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster

care through the Fostering Healthy Children Program (FHC). The nurse case managers for FHC will continue to assist foster families to access health-related and community care and to collect and document medical information for children in the foster care system.

CSHCN will continue to strengthen the community-based infrastructure for CSHCN. Bureau programs such as the Utah Medical Home Program, Family Voices and the clinics will augment community clinical services, case management and capacity building efforts to enhance a coordinated, community system of care. Utah's Family-to-Family Health Information and Education Center will provide parent-to-parent support and information on community resources and services. During this next year, the center will continue its focus on collaboration and sustainability by developing new family advocacy and interagency relationships with community-based organizations at the local, state and national level.

CSHCN programs will have a seat on the Emergency Services for Children (EMS-C) advisory board, in addition to assisting that program in enhancing access to their registry via attendance at our rural clinics to interview parents and sign up appropriate children, improving overall emergency medical services for CYSCHN throughout the State. The Bureau will also continue its work with the Oral Health Program to foster access to dental hygiene and education for families seen in our clinics.

The Newborn Follow-up Program (NFP) will continue to partner with the University of Utah and other agencies to provide multidisciplinary clinics to NICU graduates.

Continued collaboration between CSHCN clinical entities and CHARM, UHIN and CHIE will focus on implementing and expanding data sharing via CaduRx, our electronic health records system, that meet "Meaningful Use" certification for records management and billing services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	36	42.5	42.5	42.5	49.3
Annual Indicator	42.5	42.5	42.5	49.3	49.3
Numerator					
Denominator					
Data Source	See footnote for source	See footnote for source	See footnote for source	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	49.3	49.3	49.3	49.3	49.3

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 49.3% and the Annual Indicator was 49.3%.

In FY2011, the Bureau of Children with Special Health Care Needs (CSHCN) promoted and supported transition services for young adults, their families and medical providers. CSHCN employed a transition specialist who provided transition planning to young adults with disabilities and their families in Blanding, Moab, Price, Richfield and Vernal clinics. Rural Utah presents significant challenges for families in successful transition into adult services for their children. The transition specialist provided services to young adults with disabilities and their families at the Salt Lake City based CSHCN Bureau programs. In rural and Salt Lake City sites the transition specialist coordinated with local health department staff, health and mental health providers, and other state/local agencies.

The transition specialist provided onsite consultations, phone consultations and email correspondence for young adults, their families and their medical providers and consultations to community agencies.

A Memorandum of Agreement with Work Ability Utah (WAU) facilitated transition training opportunities in rural communities for medical providers. Trainings were held twice in St. George in private medical practices. Pre and post surveys were done to understand and address the specific needs of each group. While in St. George, office visits were made to other local providers and approximately 12-15 additional providers were reached. A bureau-wide training for CSHCN was conducted in Salt Lake City to help Bureau employees better understand the nature of the trainings for medical providers. Additional future trainings were scheduled for rural communities throughout the state.

The transition specialist and Medical Home Program (MHP) Representative provided transition training to Special Educators at the Utah State Office of Education Transition Round Table. The nature of the presentation only allowed for pre-surveys to be conducted.

The transition specialist maintained current resource information critical for young adults, their families and their health care providers for transition from pediatric to adult services and programs. This information was made available through onsite visits, phone consultation, email, written correspondence and the Medical Home Portal. The transition specialist attended school and community agency information fairs to disseminate transition information to young adults, parents, educators, and other community agencies.

The transition team included a SSI specialist, a Spanish-speaking social worker. He supported Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services, provided transition information and collaborated with the Office of Health Disparities Reduction each transition brochure was translated to Spanish and posted on the CSHCN website transition page and is available in hard copy.

Expanded outreach to health care providers was implemented by the transition specialist networking through participation in Department of Health committees including The Employment Partnership, Adolescent Health Network and Utah Oral Health Coalition. For The Employment Partnership the transition specialist wrote a follow-up work sheet that summarized the meeting for all members of the Partnership and made available to the public at http://blt.cpd.usu.edu/News/html. The transition specialist contributed to writing an article for Utah Chapter of the American Academy of Pediatrics quarterly publication.

CSHCN promoted other collaborative efforts for transition to continue to improve the health of the state's special needs population by working with various state/federal agencies and community programs, including: Medicaid, Social Security Administration, Utah State University Center for Persons with Disabilities (CPD), Division of Services for People with Disabilities, Utah State Office of Education, Vocational Rehabilitation, Work Ability Utah (WAU), and the Utah Developmental Disability Council.

The Medicaid Infrastructure Grant (MIG) ended on 12/31/11 the formal opportunity to provide educational transition training opportunities to health care providers in rural locations. Pre- and post-surveys were conducted to better understand and address transition issues and specific concerns.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN provided onsite transition services for young adults and their families at rural clinics and programs based in Salt Lake City. Telephone consultation, email correspondence, written communication and other supports were available.		X		
2. CSHCN conducted transition training sessions in St. George				X

and Salt Lake City, Utah for medical providers and CSHCN bureau employees. Additional trainings were planned for the upcoming year.				
3. CSHCN provided telephone consultation, written and email correspondence to providers and community agencies for needs assessment and transition planning throughout the state.				X
4. CSHCN maintained current resource information for adult services and programs.		X		
5. CSHCN expanded networks through committee participation both in and outside of the Department of Health including accepting additional responsibilities for writing and editing work sheets and quarterly columns.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In September 2012 the transition specialist duties shifted to other staff. The year included re-prioritization of duties and continued partnership with the Medical Home Program representative to promote transition to adulthood.

Children with Special Health Care Needs (CSHCN) transition duties expanded to include clinic social workers who provide onsite services to young adults with disabilities and their families both in the rural locations and urban-based CSHCN programs. Transition brochures are available at CSHCN clinic sites statewide. The transition specialist is available for telephone consultation and also provides written documents supporting parents and young adults.

The transition team includes a SSI specialist, a Spanish-speaking social worker, who provides transition information and support to the Latino young adults and their families. Each transition brochures is available in Spanish, posted on the transition page of the CSHCN website and available in hard copy.

The transition specialist developed- work sheet provides a synopsis of meetings for The Employment Partnership and contributes material for a quarterly publication of the Utah Chapter of the American Academy of Pediatrics.

The transition specialist and MHP representative attend transition fairs to disseminate resources and information in the community. The transition specialist and the MHP representative maintain current lists of resources and information.

c. Plan for the Coming Year
The transition team will update information and resources for the transition section of the CSHCN website and partner websites encompassing the spectrum of transition to adult services and programs.

The transition team will continue to develop new relationships and work collaboratively with federal, state and local agencies and organizations to provide transition services and information to young adults, families, providers and other agencies. This effort will include writing and editing articles and columns as requested. Social workers will continue to provide onsite transition services for young adults and their families both at rural clinic sites and CSHCN programs based in Salt Lake City.

The Spanish speaking SSI/Medicaid specialist will support Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services. He will collaborate with the Office of Health Disparities Reduction in providing transition information and support to Latino young adults.

After a literature review a brief transition survey for parents and young adults will be developed and disseminated in fall rural clinic sites. The data will be analyzed, compiled and reported.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	82.5	80	75.8	70.6
Annual Indicator	78.1	75.8	70.6	70.6	71.1
Numerator					
Denominator					
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	71.1	71.1	71.1	71.1	71.1

Notes - 2012
This measure does not have a numerator or denominator because it is taken from CDC's 2011 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

Notes - 2011
Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 2010 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

Notes - 2010
Data reported are the most recent data available.

This measure does not have a numerator or denominator because it is taken from CDC's 2010 National Immunization Survey (NIS) which is only available at the state level as a percentage. Data reported includes 4:3:1:3:3:1.

a. Last Year's Accomplishments
The performance measure was achieved. The performance objective was 70.6% and annual indicator was 71.1%.

The Utah Immunization Program (UIP) created the Utah School and Child Care Employee Immunization Recommendations, a list of recommended vaccines for teachers and staff following recommendations of the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices. The list was also reviewed and recommended by the Utah Scientific Vaccine Advisory Committee. The recommendations were sent out to schools statewide with recommendations for school employees to be up to date on their vaccinations. Many schools are working on employee immunization requirements or recommendations as the result of this program effort.

UIP worked closely with VFC providers to help improve pre-teen and teen immunization coverage levels in Utah. The program promoted some quality improvement strategies such as participation in the Utah Statewide Immunization Information System (USIIS); promotion of HPV, Meningococcal Conjugate, and Tdap vaccines; encouraged providers to incorporate school requirements for children k-12, not just for kindergarten entry. The program staff worked with providers in reminding them of the 7th grade immunization entry requirement, Tdap. Adolescent immunization was promoted during the statewide coalition workshop/conferences. All adolescent promotional materials were updated to reflect the new changes to the adolescent schedule.

The program promoted the immunization requirements for early childhood programs, kindergarten entry and also 7th grade entry by working closely with Head Start Programs to ensure their students are up to date with the Head Start required vaccines. The program also promoted the recommended vaccines for students, collaborated closely with the Utah State Office of Education and the Department's Bureau of Child Development, Child Care Licensing program to ensure all schools and licensed child care facilities are in compliance with the state immunization law for children in these facilities. School reporting and school audits were reviewed to ensure accurate reporting from schools. The schools are chosen from a random assignment and immunization records are reviewed and recorded with follow-up letters to school administrators.

The program worked closely with organizations representing minority populations and promoted our culturally and linguistically designed materials to these organizations as well as the Vaccine For Children (VFC) Program.

Program staff continues to work with Native American Title VII Coordinators and the Utah State Office of Education's American Indian Education Specialist to promote the program's educational materials that were created specifically with the advice of the Utah Indian Health Advisory Board for Utah American Indian tribes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VFC Provider enrollment went up by 70%. This includes pharmacies, and data interfaces with private providers.			X	
2. The Program continued education at day care centers and programs on immunization reporting to ensure correct day care reporting on immunizations for those enrolled.				X
3. Long-term cares are being enrolled in USIIS. Additionally, long-term cares are being provided education in respect to all immunization practices.			X	

4. In 2012 USIIS enrollment increased by almost 50% which includes day cares, schools, pharmacies and continued enrollment with providers through better Electronic Health Records that upload data to USIIS.				X
5. 70% of VFC providers received an AFIX quality improvement visit from Provider Relations staff.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The AFIX Program feedback sessions are being successfully implemented by the provider relations staff; a display and brochures were created to promote the program. The Utah Immunization Program (UIP) and USIIS are continuing to develop a method to use USIIS to assess immunization coverage (general population, race/ethnicity and Medicaid) levels statewide and regionally. USIIS records have resulted in an increased number of children birth to five years that have at least two vaccinations. 2013 USIIS enrollment has increased by 70%. USIIS now automatically accepts race/ethnicity data from vital records when USIIS is updated weekly with birth certificate data.

Provider representatives continue to complete approximately 250 assessments (over 50% of goal) at VFC provider offices. The electronic Immunization Reminder Service continues as an ongoing service to remind parents of timely immunizations. UIP works closely with VFC providers to help improve pre-teen and teen immunization coverage levels in Utah. The program promotes quality improvement strategies such as participation in the Utah Statewide Immunization Information System (USIIS), promoting HPV, Meningococcal Conjugate, and Tdap vaccines; encouraging providers to include school requirements for children k-12, not just for kindergarten entry. UIP works with providers in reminding them of the new 7th grade immunization entry requirement, Tdap. Adolescent Immunization is promoted during the statewide coalition workshop.

c. Plan for the Coming Year

Provider relations staff will continue to assist VFC providers with understanding immunization best practices and conduct over 250 CASA/AFIX assessments and determine coverage levels at clinics.

The Utah Immunization Program (UIP) Provider Relations Staff will continue to implement the quality improvement program, AFIX. They will work towards the goal of 70% of providers receiving face-to-face feedback on their 4:3:1:3:3:1 immunization rates every year. AFIX will be promoted to providers through VFC site visits, brochures, and participating in local conferences with the new AFIX display.

The Utah Pediatric Partnership to Improve Health Care Quality (UPIQ) project will continue recruiting providers to participate in quality improvement activities. UIP will collaborate on the Adolescent 101 project with Select Health, a Medicaid ACO, to gather data on 4:3:1:3:3:1 as well as adolescent data that is comparable and reportable by UIP to the CDC.

USIIS data will be queried to determine coverage levels based on race/ethnicity, Medicaid status and local health department areas. The annual coverage report will be disseminated to UIP partners/ stakeholders and posted online.

The UIP will continue collaboration with the regional immunization coalitions to support early

childhood immunization efforts. The UIP will continue to provide support to local health departments, community health centers and Indian Health centers for NIIW, National Immunization Awareness Month.

UIP's goal is to provide age/culturally appropriate educational/informational immunization materials to consumers. All program materials will be available in English and Spanish. The UIP will promote the VFC Program with articles in minority magazines and newspapers. We will provide education and information through media sources that target ethnic populations. Collaborations with federal, state and local Indian Health Services (where appropriate) to provide immunization information among ethnic populations (especially American Indians) will be initiated. Our goal is to continue our work with Utah Indian Health Advisory Board to create culturally and linguistically appropriate posters, radio ads, and articles in Native American tribal newsletters/newspapers to promote immunizations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16.5	18.5	18.5	16.5	14.3
Annual Indicator	18.5	16.5	14.3	11.2	11.2
Numerator	1122	995	876	706	706
Denominator	60796	60127	61154	63253	63253
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	11.1	11	11	10.9	10.8

Notes - 2012
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011
Denominator: IBIS Population estimates for 2011

Notes - 2011
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011
Denominator: IBIS Population estimates for 2011

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: IBIS Population estimates for 2010

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 14.3 and the Annual Indicator was 11.2.

The Utah Department of Health (UDOH), Maternal and Child Health Bureau, Maternal and Infant Health Program (MIHP) continued to receive funding from the U.S. Department of Health and Human Services (HHS), Administration for Child and Families to implement Personal Responsibility Education Programs (PREP) and Abstinence Education Programs to reduce teen pregnancy in Utah. Funds for PREP were used to implement community programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS, and provided other adulthood preparation subjects.

MIHP sub-contracted most of the PREP funds out to local organizations through a competitive grant process. Those organizations who received funding were: Bear River Health Department, Boys and Girls Clubs of Greater Salt Lake, Club Red: Moab Teen Center, Centro Hispano, Teen Mother and Child Program, and the Weber-Morgan Health Department. Among the six funded agencies, the following populations were served: Utah youth ages 14-19 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, teen mothers, and youth residing in areas with teen birth rates higher than Utah's state rate.

MIHP also continued to sub-contract Abstinence Education funds to local organizations through a competitive grant process. The organizations that received funding were: National Tongan American Society, Planned Parenthood Association of Utah, Pregnancy Resource Center of Salt Lake, Tooele County Health Department, Utah County Health Department and the Weber-Morgan Health Department. Among the six funded agencies, the following populations were served: Utah youth ages 10-16 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, and youth residing in areas with teen birth rates higher than Utah's state rate.

The Adolescent Health Coordinator continued to oversee the Utah Adolescent Health Network, a group of diverse stakeholders of adolescent health from government, academic, non-profit, and community organizations. The Network served as a venue for overall adolescent health professional development. Quarterly network meetings were held and included presentations by experts in general adolescent health topics, presentation discussions, and member networking and project sharing.

The Adolescent Health Coordinator monitored, analyzed, and released Utah teen pregnancy, birth and STD data. These data were distributed among the Adolescent Health Network, various media and legislative entities, and maintained on the State of Utah's, Department of Health, Indicator-Based Information System for Public Health (IBIS-PH).

MIHP continued to work on reaching the UDOH Teen Pregnancy goal. The goal was set for year 2015 to decrease the rate of teen pregnancies to 31.7 per 1,000 Utah females ages 15-19. In 2010 (the most current data available), the rate was 32.0 per 1,000 Utah females ages 15-19. The Adolescent Health Coordinator continued to monitor and share state birth and pregnancy data pertaining to this goal.

MIHP continued to distribute the teen "life plan" entitled: Plan Your Health: Live Your Life among Utah adolescents and community groups. Developing additional tools to accompany this plan was put on hold until the Health Education Specialist position is filled at the Utah State Office of

Education.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH provided oversight for the PREP and AB ED Programs.				X
2. MCH provided oversight of the Utah Adolescent Health Network.				X
3. MCH Monitored, analyzed, and released Utah teen pregnancy, birth and STD data.				X
4. MCH distributed the Plan Your Health, Live Your Life, Teen Life Booklet to Utah Adolescents.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maternal and Child Health Bureau continues to oversee the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF) federal funding for the Title V State Abstinence Education Program and Personal Responsibility Education Program (PREP). The Adolescent Health Coordinator provides project oversight and technical assistance to 13 funded community-based projects. A part-time Research Analyst in the Maternal and Infant Health Program (MIHP) was hired to assist with the PREP program evaluation needs.

The Adolescent Health Coordinator continues to oversee the Utah Adolescent Health Network. Two Network meetings have been held thus far this year. Both meetings included a presentation or training by an expert in a general adolescent health topic, time for discussing the topic, and time allotted for member networking and project sharing. The two presentations provided were: 1) Teen Driving Safety, and, 2) Best Practice Recommendations for Transitioning Adolescent Foster Girls.

MIHP continues to work on reaching the UDOH Teen Pregnancy Goal. The goal was set for year 2015 to reach the rate of 31.7 per 1,000 females (ages 15-19). The current rate based on 2010 birth data is 32.0 per 1000. The Adolescent Health Coordinator continues to monitor and share state birth and pregnancy data pertaining to this goal.

c. Plan for the Coming Year

The Maternal and Child Health Bureau will continue to oversee the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), federal funding for the Title V State Abstinence Education Program and Personal Responsibility Education Program (PREP). The Adolescent Health Coordinator will carry out oversight and technical assistance to funded community-based projects. The abstinence education projects target Utah youth ages 10-16 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, and youth residing in areas with teen birth rates higher than Utah's state rate. All funded abstinence programs must ensure that abstinence from sexual activity is the expected outcome as outlined in the federal requirements. PREP projects will focus on programs designed to educate adolescents on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS and preparation for adult life. PREP will target

Utah youth ages 14-19 with a specific focus on youth in the Utah Juvenile Justice System, youth of Hispanic origin and/or non-white race, current teen moms, and youth residing in areas with birth rates higher than Utah's state rate.

The Maternal and Infant Health Program will update and monitor the Adolescent Health section of the program website. Additional pages will be added specifically for the Abstinence Education and PREP sub-awardees.

The Adolescent Health Coordinator will continue to oversee the Utah Adolescent Health Network, which will serve as a venue for overall Adolescent Health professional development and training. Network meetings will be held each quarter and will include a presentation or training by an expert in a general adolescent health topic, time for discussing the topic, and time allotted for member networking and project sharing.

The State met the Utah Teen Pregnancy Goal: By the year 2015, the Utah pregnancy rate among girls between the ages of 15-19 will be 31.7 per 1,000 females. In 2011, the teen birth rate was 27.0 per 1,000. The Adolescent Health Coordinator will continue to monitor and share state birth and pregnancy data pertaining to this goal and work towards continued reduction. The 2010 Utah Adolescent Reproductive Health Report will be updated to include the most recent data. This updated report will be released in the Fall or Winter of 2013.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	45.1	45.1	45.1	41.9	41.9
Annual Indicator	45.1	45.1	41.9	41.9	41.9
Numerator	155	155	392	392	392
Denominator	344	344	935	935	935
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	41.9	41.9	41.9	45	45

Notes - 2012
Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
Unweighted=40.2%, weighted=41.9%

Notes - 2011
Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
Unweighted=40.2%, weighted=41.9%

Notes - 2010
Utah Oral Health Survey 2010, 3rd grade data, Oral Health Program, UDOH
Unweighted=40.2%, weighted=41.9%

Because our original objectives were set higher than what we had achieved in 2010, we adjusted down the performance objectives for subsequent years as we will not have new data available until 2015.

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 41.9% and the Annual Indicator was 41.9%.

A statewide survey of first through third grade children was performed during 2010 and the final report was released in 2012. During FY12, DFHP Oral Health Program (OHP) promoted sealants through screening and referral activities. The OHP supported direct delivery of sealants at the local health department level, and promoted education/awareness programs among dental professionals, pediatricians and the public. The OHP concentrated on collaborating with Sealant for Smiles in training staff and in providing screening and referring procedures for children attending high-risk elementary schools in Salt Lake, Davis and Tooele counties.

The OHP supported and provided technical assistance in collaboration with Dental Select's sponsored Sealants for Smiles school-based preventive dental program. In spite of decreased funding the Sealant for Smiles program provided education and directs service to schools in Davis, Tooele and Salt Lake Counties. Nearly 6,000 children were screened and almost 16,000 sealants placed on low-income uninsured and Medicaid/CHIP insured children.

The OHP also supported and provided technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental Hygiene programs at Weber State University, Utah Valley State College, Utah College of Dental Hygiene and Dixie College. Sealant Projects in the Weber-Morgan Health Department, Utah County Health Department and Southwest Utah Health Department included health department and school personnel, volunteer dental hygienists, dentists and dental assistants.

The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and Community Health Center dental clinics promoted oral health prevention including sealant utilization to the public. Other activities included making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OHP provided technical assistance for local health department to form local Oral Health Task Forces and emphasize placement of dental sealants.				X
2. OHP used data from statewide survey of 6-9 year old children to develop strategies for direction efforts to reduce the percentage of children with untreated dental decay and increased the number of children with dental sealants.				X
3. OHP supported and provided technical assistance to Sealants for Smiles for free sealants to low-income and underinsured first				X

through sixth grade children in Salt Lake, Davis, and Tooele Counties.				
4. OHP supported the prevention and education activities of the Utah Oral Health Coalition in the promotion of dental sealants.				X
5. OHP worked with Sealant for Smiles in modifying the program developed by the American Association of Community Dental Programs called “Seal America” and used as a guide to promote dental sealant programs at the community level.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FY13, DFHP Oral Health Program (OHP) is promoting dental screening, sealant and referral activities. A statewide survey of 6-9 year old children was performed in 2010 with a report published in 2012. Results of the survey indicate improvement in oral health among Utah children since 2005. However, sealants remain underused in Utah with only 36.1% of 8 year olds having sealants compared to 45.1% in 2005. The OHP is supporting direct delivery of sealants at the local health department level, and promoting education/awareness programs among dental professionals, pediatricians and the public.

The OHP is collaborating, supporting and providing technical assistance to Dental Select's Sealant for Smiles school-based preventive dental program. Reduced funding has necessitated canceling schools in Summit County and scaling back projected goals in Tooele, Davis and Salt Lake counties. Nonetheless, it is anticipated that more than 7,000 low-income uninsured and Medicaid/CHIP insured children will be screened and have sealants placed.

The OHP is supporting and providing technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental Hygiene programs statewide. Other activities include making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote sealants.

c. Plan for the Coming Year
During FY14, DFHP Oral Health Program (OHP) will promote sealants through screening and referral activities. Results from the statewide survey of 6-9 year old children will help direct OHP activities in the future. The OHP will support direct delivery of sealants at the local health department level, and promote education/awareness programs among dental professionals, pediatricians and the public. The OHP will concentrate on training local health departments on screening and referral procedures for children attending high-risk elementary schools in their communities.

The OHP will support and provide technical assistance in collaboration with Dental Select's Sealant for Smiles school-based preventive dental program. It is hoped that additional funding will be made available to allow the Sealant for Smiles program to expand to include more schools in Tooele, Davis and Salt Lake counties. It is anticipated that more than 7,000 children will be screened and over 18,000 sealants placed on low-income uninsured and Medicaid/CHIP insured children. Plans are being made to expand the program statewide.

The OHP will also support and provide technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental

Hygiene Programs at Weber State University, Utah Valley State College, Utah College of Dental Hygiene and Dixie College. Sealant Projects in the Salt Lake County, Weber-Morgan, Utah County and Southwest Utah health departments will include health department and school personnel, volunteer dental hygienists, dentists and dental assistants.

The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and Community Health Center dental clinics will promote oral health by including sealant utilization and other dental disease preventive measures to the public. Other activities will include making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.
OHP will work with programs in CSHCN to promote good oral health among the most vulnerable children, those with special health care needs. The dental hygienist will travel to rural clinic sites to screen and apply fluoride varnish on the teeth of children seen in rural CSHCN clinics.

The OHP will continue to work with Head Start Programs, pediatricians and other non-dental health care providers in promoting early caries prevention programs including oral health risk assessment and fluoride varnish application.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.5	3.4	4.3	2.2	2
Annual Indicator	4.6	2.2	2.0	2.8	2.8
Numerator	33	16	15	21	21
Denominator	723026	736615	749214	749774	749774
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	2.8	2.7	2.6	2.5	2.5

Notes - 2012
Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2011
Denominator: IBIS Population estimates for 2011

Notes - 2011
Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2010
Denominator: IBIS Population estimates for 2010

Notes - 2010

Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality Data: Injury Query, UDOH, 2010
Denominator: IBIS Population estimates for 2010

a. Last Year's Accomplishments
The Performance Measure was not achieved. The Annual Performance Objective was 2.0 and the Annual Indicator was 2.8.

The Violence and Injury Prevention Program (VIPP) provided funding and assistance to each of Utah's 12 local health departments (LHDs) to conduct local injury prevention programs on child passenger safety, bicycle, pedestrian, and motor vehicle safety. Approximately 176,559 people were reached through 1,296 events promoting motor vehicle, pedestrian, and bicycle safety. In addition, there were 130 media events conducted by the LHDs and VIPP such as PSAs, press conferences, media interviews, and news releases.

VIPP continued to provide data and surveillance expertise and support to a variety of partners including LHDs, state agencies, and legislators. "The Child Injury Deaths in Utah" report was produced which breaks down child deaths by age, sex, geographic location, and circumstances (e.g., ATV deaths, motor vehicle crashes, etc.), as well as provides recommendations for prevention.

VIPP worked with LHDs to promote use of child safety seats through Safe Kids Utah. VIPP remained the lead agency for Safe Kids Utah, with LHDs required to participate in their local chapter/coalition. There are 13 active Safe Kids coalitions/chapters across the state, which provide education, awareness, and prevention activities targeting children ages 1-14, such as Safe Kids Week, National Child Passenger Safety Week, etc. VIPP and the LHDs conducted 53 car seat checkpoints, correctly inspected and installed 2,111 car seats and booster seats, and distributed 1,568 low-cost car seats and booster seats to families in need during FY12. There were also 2,793 bicycle helmets distributed. VIPP coordinated 18 media events and requests on motor vehicle safety and children.

The "Click it Club" program, developed for adolescents to improve seat belt use, is being implemented by many LHDs in conjunction with the Zero Fatalities program. Several child passenger safety technician trainings were held in rural areas of the state, greatly increasing the LHDs' capacity to conduct child safety seat inspections and checkpoints in the future. Multiple LHDs participated in re-certification trainings for technicians whose certification was close to expiring.

The VIPP continued to co-chair the Utah Teen Driving Task Force to coordinate efforts of state, local, and private agencies working together on the issue of reducing teen motor vehicle crashes. Behaviors learned as young children may impact decisions later on in life such as wearing seat belts, which are reflected in teen driving outcomes. VIPP coordinated a statewide teen driving campaign with the LHDs, which has been a priority area for more than five years.

Teen driving activities are targeted to 15-19-year-olds since they are involved in 20% of all crashes, but only represent 8% of licensed drivers in Utah. LHDs conducted more than 160 events reaching approximately 22,000 Utah teens and 1,300 parents in FY12. These numbers do not include activities conducted by the contractor with the statewide teen driving media campaign, Zero Fatalities. These events have also yielded positive seat belt use results, with increased seat belt use rates in most health districts anywhere from 25%-83% during the fall pre-surveys to 53%-86% at the spring post-survey.

VIPP responded to 10 media requests on teen driving and held one press event to release the 4th teen memorial book. The teen memorial book is a collection of stories told by grieving families who have lost a teen in a motor vehicle crash. VIPP has published a memorial book since 2008.

Since October 2011, the 2010 teen memorial book has been downloaded more than 10,000 times. This does not include downloads from the past three teen memorial books in 2007, 2008, and 2009. High school students reported they were more likely to follow driving laws and understand the risk associated with driving after reading the book. Additionally, 95% of the students said it should be required reading for all driver education students.

Education efforts by VIPP, LHDs, and the Utah Teen Driving Task Force have led to an astounding 61% decrease in the rate of teens killed in motor vehicle crashes since 1998, when the Utah Graduated Driver Licensing laws were enacted.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VIPP provided funding to the LHDs to conduct 53 checkpoints, correctly check and install 2,111 child safety seats during community checkpoints or appointments at the LHD, and distribute 1,568 low cost car seat or booster seats to needy families.			X	
2. VIPP provided funding to the LHDs to conduct 1,296 activities such as classes, presentations, bike rodeos, pedestrian safety events, assemblies, safety fairs, and safety events reaching over 176,559 individuals.			X	
3. The majority of these VIPP Funded events focused on child passenger safety and motor vehicle safety for children and teens. In addition, there were 130 media events such as PSAs, press conferences, media interviews, and news releases.			X	
4. VIPP remained the lead agency for Safe Kids Utah and required each of Utah's 12 LHDs to be an active participant or sponsor of their local Safe Kids coalition/chapter as part of their injury prevention contract with VIPP.				X
5. The funding and training provided to LHDs for a statewide campaign to promote teen motor vehicle safety resulted in more than 160 events, reaching approximately 22,000 Utah teens and 1,300 parents.			X	
6. LHDs conducted seat belt use observation studies in targeted high schools. Overall observed seat belt use was 69% in FY2012. The seat belt use in high schools ranged from 25%-83% during the fall surveys to 53%-86% in the spring survey.			X	
7. VIPP developed the fourth teen memorial booklet sharing stories of teens killed in motor vehicle crashes. Booklets are distributed to driver education classes statewide. Since October 2011, the 2010 memorial book was downloaded more than 10000 times.			X	
8. VIPP continued to provide data and surveillance expertise and support to a variety of partners including LHDs, state agencies, and legislators.				X
9. The Child Injury Deaths in Utah report was produced which breaks down child deaths by age, sex, geographic location, and circumstances (e.g., ATV deaths, motor vehicle crashes, etc.), as well as provides recommendations for prevention.				X
10.				

b. Current Activities

VIPP collaborates with partners to implement strategies to reduce motor vehicle crash deaths among children. This coordination is vital to statewide implementation and success. Funding and technical assistance are provided to each of Utah's 12 local health department (LHD) to address traffic safety issues. LHDs primarily focus on child passenger safety, pedestrian, and bicycle safety via Safe Kids coalitions/chapters and teen driving safety in partnership with the Zero Fatalities campaign. VIPP is coordinating a statewide campaign with LHDs and other partners to reduce teen motor vehicle deaths. Each year, the VIPP contacts families of teens who died in a motor vehicle crash to participate in a Teen Memorial Book. FY13 will mark the 5th year a memorial book has been created. VIPP leveraged funding from CDC to provide eight LHDs funding to conduct a Parent Night Program. Together, VIPP and Zero Fatalities staff developed a 1 to 11/2 hour class for parents who have children enrolled in driver education classes, based on other evidence-based programs. A parent guide was developed to supplement the class. VIPP also provides statistical support to its many partners and legislators. VIPP provides weekly legislation updates to partners during the legislative session and developed a fact sheet on teen cellphone use while driving. VIPP will remain the lead agency for Safe Kids Utah. VIPP will support LHDs to promote proper use, conduct inspections, and distribute low cost seats.

c. Plan for the Coming Year

VIPP will continue collaboration work with its many partners to implement strategies for reducing motor vehicle crash deaths (MVCs) among children in Utah. The Child Fatality Review Committee will continue to review all child deaths and give recommendations for system and policy changes, education, and interventions to prevent future deaths.

Funding, training, and technical assistance to each LHD will be provided to conduct injury prevention interventions. Small area data will be provided to each LHD to guide the development of their contract activities to the highest priorities in their health districts.

VIPP will remain the lead agency for Safe Kids Utah and oversee coalitions statewide. Car seat efforts will include: partnering with Safe Kids Utah and LHDs to promote proper use of car/booster seats; conduct car seat inspections; assist with technician training; distribute low-cost car seats; educate children (grades K-12); work with media; and, provide information on the VIPP and Safe Kids Utah websites.

VIPP will continue to coordinate and co-chair the Utah Teen Driving Task Force with the Utah Highway Safety office. VIPP will also coordinate a campaign with all LHDs aimed at reducing deaths to teens, 15-19 years of age, from motor vehicle crashes. Multifaceted interventions will include: education; mobilizing partnerships to solve traffic safety problems; partnering with law enforcement; partnering with Zero Fatalities and drivers education classes to teach the Parent Night Program class about GDL laws, and creation of a 6th Teen Memorial book. Younger children will also be taught about safe driving as passengers and to prepare them for the responsibility of driving in a few years through the "Click it Club", and "Countdown To Drive" programs. The 2012 Teen Memorial Book will be produced and distributed statewide through Driver Education classes.

VIPP will continue to work with the Utah Brain Injury Council to produce reports and training on motor vehicle crashes as a major cause of traumatic brain injuries. Pedestrian and bicycle safety efforts conducted by the LHDs will be overseen by VIPP. Efforts will include distribution of helmets, pedestrian safety events (Green Ribbon Month, Safe Routes to School, and Walk to School), and coordination with enforcement agencies. Although bicycle and pedestrian safety activities will be implemented as in previous years, LHDs will scale back these efforts in FY14 because of funding cuts from the Utah Highway Safety Office. Pedestrian and bicycle safety activities are often used by the LHDs to garner support from community partners which lead to more effective interventions in child passenger safety and teen driving.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	56	60.5	69.6	58.5	61.5
Annual Indicator	60.4	69.5	61.5	61.5	64.4
Numerator					
Denominator					
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	65	65.2	65.5	66	66

Notes - 2012
Data reported are the most recent data available.
The data reported are from the National Immunization Survey, 2009. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2011
Data reported are the most recent data available.
The data reported are from the National Immunization Survey, 2008. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2010
Data reported are the most recent data available.

The data reported are from the National Immunization Survey, 2008. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 61.5% and the Annual Indicator was 64.4%.

The U.S. national average for breastfeeding at 6 months was 47.2%. The Healthy People (HP) 2020 goal for this indicator is 60.6%; Utah is one of only three states that have surpassed the goal. The National Immunization Survey data (2009-preliminary) indicate that Utah's breastfeeding rates were above the HP 2020 objectives in all but one indicator. Utah's rate of exclusive breastfeeding at six months was 24.8% and the HP objective is 25.5%.

In celebration of World Breastfeeding Week, Breastfeeding' Cafés were sponsored in August 2011. Utah Breastfeeding Coalition (UBC) members, peer counselors, La Leche League Leaders, WIC registered dietitians, IBCLCs collaborated to support this community event in locations

throughout the state.

As part of a series for each of the twelve health departments across Utah, four luncheons were sponsored to bring the breastfeeding support community together to meet and share resources. Professionals and paraprofessionals such as IBCLCs, RNs, WIC peer counselors, doulas, and lactation support business owners came together to share resources, pass out business cards, and connect to help inform each other about all the different ways we can support breastfeeding.

The UBC provided assistance and technical support to local businesses to implement the workplace law to support nursing women. The Business Case for Breastfeeding and other information were disseminated to businesses.

The newly formed Utah Human Milk Bank Taskforce selected a Medical Director and a Board of Directors. The taskforce started the application process for becoming a human milk bank and is reaching out to NICUs across the state to promote the use of donated human milk.

The Women, Infants and Children (WIC) Program continued to implement the new food rules that limit formula issuance and increase breastfeeding assessment and counseling. All new staff was trained on the breastfeeding promotion curriculum "Grow and Glow". A 45-hour Comprehensive Lactation Course was offered to local WIC staff and community partners; approximately 95 participants attended. WIC agencies provide prenatal and postpartum breastfeeding classes to women; 18 IBCLCs were on staff in local clinics statewide. In addition, the WIC Breastfeeding Peer Counselor Program expanded to provide services throughout the state with 54 employed peer counselors. A new online Peer Counseling Project is being developed in Utah; it is a web-based, secure, social networking platform that allows for WIC participants to receive assistance from a peer counselor through their mobile or laptop device. Breastfeeding educational meetings were held at two Salt Lake Valley Health Department clinics for WIC peer counselors.

Utah WIC completed the first full year of using the newly developed computer system which incorporates USDA's system requirements on breastfeeding. Breastfeeding prevalence and evaluation reports were designed and tested.

The Physical Activity Nutrition and Obesity (PANO) Program contracted with 4 local health departments that worked with 51 child care facilities to implement the TOP Star Program, which includes breastfeeding best practices. PANO provided information and resources to a Utah State Representative who developed and introduced the Joint Resolution on Breastfeeding (HJR4) encouraging employers to provide accommodations for breastfeeding employees, which was passed by the 2012 Utah legislature. The Utah PANO health care work group, in partnership with the Utah Medical Association, published an article in the Utah Medical Association newsletter on "Breastfeeding for Pediatricians".

The Pregnancy Risk Line participated in the presentation of the CDC collaborative study on breast fed infants during the 25th International Organization of Teratology Information Specialists (OTIS) conference. Staff piloted a follow-up survey with breastfeeding callers. Survey questions were modified and placed in web-based survey software.

The MIHP published a report "Breastfeeding in Utah: Initiation, Continuation, and Barriers" using 2009-2010 Utah PRAMS data. The report was sent to the nurse managers in each of the 44 delivering facilities statewide as well as published to the MIHP website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding 'Cafés across the state celebrated World			X	

Breastfeeding Week.				
2. A major conference was held with an internationally known breastfeeding speaker.				X
3. The Department was engaged in promotion of Baby Friendly Businesses and the establishment of worksite lactation programs.				X
4. The newly formed Utah Human Milk Bank Taskforce held monthly meetings, established a medical director and a board of directors, and started the formal process of submitting a state application to the national organization.				X
5. The WIC program implemented new food rules limiting formula issuance and increasing breastfeeding counseling.		X		
6. WIC sponsored a 45-hour comprehensive lactation training for 95 WIC staff and community health professionals including 18 IBCLCs on staff.				X
7. The WIC Breastfeeding Peer Counselor Program expanded and training was provided throughout the state.				X
8. The WIC program continued to test and modify its statewide computer system regarding all breastfeeding related components.				X
9. The On-Line Peer Counseling Program started development as a new state model for the nation.				X
10. Pregnancy Risk Line participated in the poster presentation of a CDC collaborative study during the international OTIS conference and piloted a follow-up survey of breastfeeding callers.			X	

b. Current Activities

The Healthy Utah Babies workgroup continues to work together to increase the number of Utah hospitals that are implementing the 10 Steps to Successful Breastfeeding. The Workgroup has developed a survey for hospitals in Utah on Breastfeeding Supportive Maternity Care practices. The results will be used to identify hospital's biggest barriers to successful breastfeeding. Hospitals will be engaged in effective multi-disciplinary Quality Improvement Teams. The Utah Breastfeeding Coalition (UBC) sponsored a conference with internationally known breastfeeding speaker, Nils Bergman from Australia that was attended by 250 Utah health professionals. UBC continues its series of networking luncheons and compilation and dissemination of a new Community Breastfeeding Resource Guide and listings of Baby Friendly Businesses. The Physical Activity Nutrition and Obesity Program (PANO) contracts with 6 local health departments to implement TOP Star, which provides training and technical assistance to child care providers regarding breastfeeding best practices. PANO developed and is launching a new website with breastfeeding resources for worksites and health care providers. PANO is developing a web-based training module for child care providers on Supporting the Breastfeeding Mother. Pregnancy Risk Line is continuing outreach efforts to low-income risk groups by attending local health fairs and will also continue its breastfeeding survey.

c. Plan for the Coming Year

The Utah Perinatal Quality Collaborative (UPQC) is being formed to improve perinatal and neonatal service quality in Utah. The UPQC will be a statewide, multi-stakeholder network dedicated to improving perinatal outcomes in Utah. Areas of focus will be determined by UPQC membership; however quality improvement projects related to preterm births, neonatal morbidities and implementation of the 10 Steps to Successful Breastfeeding will be among the top priorities.

One of the outcomes of the Breastfeeding Supportive Maternity Care practices survey being

carried out during 2013 will be to voluntarily engage delivery hospitals throughout the state in effective multi-disciplinary Quality Improvement Teams to begin a process of collaborative learning using the Plan-Do-Check-Act Cycle model in order to be certified by the state of Utah as Breastfeeding Friendly. This work will fall under the umbrella of the new UPQC currently being formed.

Breastfeeding' Cafés will be held across the state in celebration of World Breastfeeding Week and worksite breastfeeding support will continue to be promoted with the dissemination of the Business Case for Breastfeeding promotional materials.

The WIC program will continue to offer training opportunities to staff including comprehensive lactation courses and will work towards increasing the number of International Board Certified Lactation Consultants (IBCLCs) staffed statewide. WIC will also continue to obtain national curricula, educational materials and guidelines to disseminate and providing training statewide. As part of state policy, all new WIC staff will complete the national breastfeeding curriculum "Glow and Grow" and will receive educational resources and materials. In addition, the WIC Breastfeeding Peer Counselor Program will continue to promote and support breastfeeding. The Online Peer Counseling Program will be implemented to all county agencies and will be the first in the nation to provide this type of social media networking through WIC.

WIC will continue to implement the food rules that limit formula issuance, increase breastfeeding assessment and counseling and collaborate with local community, state, and national organizations to better promote, support and protect breastfeeding. WIC will also continue to provide a variety of manual and electric breast pumps and prenatal and postpartum breastfeeding classes.

The Physical Activity Nutrition and Obesity Program will contract with 7 LHDs to provide training, technical assistance, and support to child care providers regarding breastfeeding best practices. PANO plans to partner with the University of Utah to survey worksites and provide training on compliance with the Affordable Care Act provision supporting breastfeeding employees.

Pregnancy Risk Line will develop a marketing and education campaign on pharmacology and breastfeeding called Mother-To-Baby Utah directed at hospital lactation specialists and WIC educators.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	97.5	97.9	98.1	98.3	98.6
Annual Indicator	98.1	98.3	98.6	98.8	98.8
Numerator	55705	54225	52624	51661	51661
Denominator	56788	55143	53395	52288	52288
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	98.8	98.8	98.9	98.9	98.9

Notes - 2012
Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2011

Notes - 2011
Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2011

Notes - 2010
Data reported are the most recent data available.

Numerator: Utah Hearing, Speech, and Vision Services Program, Hi*Track database, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, occurrent births, UDOH, 2010

a. Last Year's Accomplishments
Performance measure was achieved. Performance Objective was 98.6% and Annual Indicator was 98.8%.

Newborn hearing screening is done at all 42 Utah hospitals, the pediatric specialty hospital, and 7 birth centers. Utah had 52,288 births in 2011 with over ninety-eight percent (98.6%) being screened for hearing loss. The pass rate for those screened was 98.6%, with 49,771 (97.7%) passing by one month of age. Homebirth screening rates increased from 69% in 2010 to 75.3% for 2011 births. Four hundred seventeen (417) newborns were referred for diagnostic evaluation. One hundred four (104) infants were identified with permanent hearing loss. Approximately 1.4% of Utah's 2011 newborns have not returned for outpatient/diagnostic testing, have no screening results reported, or missed newborn hearing screening (improvement of 0.3%). Targeted efforts are increasing to meet national 1-3-6 EHDI (Early Hearing Detection and Intervention), aka newborn hearing screening (NBHS) goals.

Utah EHDI continued focus on decreasing the number of infants lost to follow-up or documentation and improving program success. Three lay midwife programs were added to the Homebirth Hearing Project (eighteen Otoacoustic Emission screening units placed through June 2012), increasing rural and non-hospital screenings. State EHDI re-introduced the Early Head Start collaboration, meeting with the regional Early Childhood Hearing Outreach director and Head Start in November 2011. A MOU was drafted and approved between Early Head Start and Utah EHDI. Davis County Early Head Start was the first to partner with state EHDI. In September, 2011, Utah EHDI hosted an annual conference for NBHS audiologists, coordinators, and screeners. We focused on problem-solving difficult cases, trouble-shooting screening processes, data and program management to improve 1-3-6 objectives and devising statewide protocols for the screening of special at-risk populations. A Pediatric Audiology conference entitled, "Jump-Starting the EHDI Process: Accurate and Efficient Diagnostic Audiology for Infants" was hosted in September 2011; 41 audiologists attended. Almost 95% rated the conference as excellent.

Trainings such as these are critical components in our state reduction plan of EHDI LTF-U.

Two EHDI staff attended the Investing in Family Support Conference; EHDI: Partnering for Progress in Raleigh, NC in October 2011. A teleconference in December 2011 with state EHDI and Utah Hands & Voices (H&V) discussed plans for family/parent support activities and possible collaboration with "Guide by your Side". Utah H&V presented at the February, 2012 NBHS Advisory meeting. H&V brochures are included with our Parent Notebook for families having a child newly diagnosed with hearing loss. "Connecting EHDI Data to an Electronic Health Information Exchange" was presented at National EHDI in March 2012. Two staff audiologists attended a "Diagnostics and Amplification for Infants and Toddlers" workshop in Boise, ID, in June 2012.

All hospitals upgraded to HiTrack 4.5.5 data tracking system, allowing streamlined filtering and tracking options, editable Transfer History records, enhanced diagnostic data entry, improvements to CDC criteria reports, additional tools for HiTrack Web and Web companion, and support of incoming HL7 2.x admissions messages. Weekly hospital data reporting to State EHDI was implemented in April 2012 to enable timely data corrections, earlier tracking and better matching in newborn data integration projects. Reports were utilized to assess hospital issues. Eleven hospital site visits were completed. Action plans were initiated to address individual program needs. Annual regional meetings (4) in the spring of 2012 focused on follow-up activities, new reporting requirements, using HiTrack to achieve performance standards, audiology follow-up and hearing loss risk factors.

Web-enabled HiTrack beta testing by two audiologists was initiated. Both provided feedback monthly on connection, tracking and reporting issues. Both successfully input audiology results, accessed notes/results for cases they follow and ran reports directly from State HiTrack. State EHDI updated the EHDI Guide to Pediatric Audiologists and distributed to pediatricians, family providers, audiologists, and ENTs along with information on the legislative requirement to report hearing loss. These efforts will improve completion of 2nd screens, reduce loss to follow-up and provide more complete reporting to HiTrack.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. NBH hosted a Pediatric Audiology Conference, in addition to the annual Utah Early Hearing Detection and Intervention (EHDI) Conference.				X
2. The program noted an Increase in the overall number of homebirth screenings statewide.			X	
3. The program updated the HiTrack (hearing) data management and tracking system.				X
4. Program staff attended the National EHDI and Family Support Conferences.				X
5. NBHS continued activities to address uniform standards in screening, diagnostic testing, training, and development of pediatric standards and protocols.				X
6. The Program increased collaboration with community partners, including Early Childhood Hearing Outreach (ECHO) Early Head Start, Fostering Healthy Children and Utah Hands & Voices.				X
7. The program updated the Utah EHDI Parent Notebook, "An Interactive Notebook for Families With a Young Child Who is Deaf or Hard of Hearing".		X		

8. The program completed beta testing with two Newborn Hearing Screening Supervising Audiologists for web-enabled HiTrack.				X
9. The program regularly ran scheduled client matching between Utah Vital Records and HiTrack via demographic data upload to improve the reporting of individually identifiable, un-duplicated information.				
10. The program integrated B-TOTS (Early Intervention) database through The Child Health Advanced Records Management (CHARM) which allows real-time access to hearing screening and follow-up information to all Early Intervention programs statewide.				X

b. Current Activities

A State EHDI Conference and regional training workshops for hospital screening coordinators and audiologists is scheduled to be held. The Utah EHDI Training manual and Utah Guide to Pediatric Audiologists are being updated, and will be published and distributed. A Hospital NBHS Self-Assessment Tool is being instituted; hospital site visits will be made. Hospitals are being upgraded to Web-enabled HiTrack to help improve EHDI data quality, tracking and follow-up. The NBHS and Hearing Loss modules for the Medical Home Portal are being updated in conjunction with the Utah AAP EHDI Chapter Champion. We will collaborate with Davis County Early Head Start to share newborn hearing data to reduce the number of children who are lost to follow-up or documentation. Utah EHDI plans to pilot a "proof of concept" tele-audiology project, to provide Auditory Brainstem Response evaluation remotely via telehealth for infants in rural Utah with failed screenings. This project will be evaluated and reported at the Newborn Hearing Screening Advisory Committee, the AMCHP Conference and the National EHDI Conference. Current EHDI projects and an overview of State EHDI will be presented at the Utah Speech-Language-Hearing Association conference. We plan to host a 2-day audiology workshop on infant electrophysiologic testing to increase the numbers of pediatric audiologists trained to provide diagnostic testing in infants to improve Utah's attainment of the national 3 month goal for diagnosis.

c. Plan for the Coming Year

During FY14, we will continue to focus on decreasing loss to follow-up after failed newborn hearing screening and increasing support for the national 1-3-6 EHDI goals. We will work to improve the achievement of newborn hearing screening goals for families who have limited access or resources and increase the tracking and reporting capabilities for these infants. Our Follow-up Coordinator will initiate additional strategies to decrease the number of infants missed and/or lost to follow-up (or lost to documentation) after a failed first screening. HiTrack reports will be added to track progress. Program audiologists will initiate a process to monitor failed screenings/evaluations, and decrease the number of infants who go beyond three months between failed hearing screening and a diagnosis. The Homebirth Hearing Project will be expanded and additional referral strategies will be determined. Development of a lay midwife screener consortium and a Utah EHDI conference for lay midwives will be explored. A Memorandum of Understanding (MOU) for the sharing of EHDI data will be created with our border states, beginning with Wyoming and Idaho. Staff will attend the National EHDI conference to develop program improvement activities. A statewide annual Utah EHDI conference will be provided. Regional workshops and hospital site visits will target individual program needs and challenges. All Utah HiTrack (HT) hospital users and supervising audiologists will upgrade to web-enabled HT by 2014.The capacity of both the database and web servers will be increased to better serve all hospital, audiology, State Team and CHARM users. Account security enhancements will be added. Technical support and training will be provided. A GoTo Meeting tutorial will be hosted for hospital coordinators/audiologists. Development will begin for Person-Specific log-in to HiTrack Web for private audiologists.

Continued data integration projects through the Clinical Health Information Exchange, Utah

Health Information Network, CHARM, and Baby Watch Early Intervention (BTOTS) will increase avenues to link health information systems and decrease infants lost to tracking/documentation. The data sharing agreement will be rewritten to address the most recent FERPA regulations to facilitate this exchange. CHARM linkage to the Utah School for the Deaf and Blind (USDB) Parent-Infant-Program (PIP) will be developed. Newborn screening results (heel stick and hearing) will be available to electronic medical records (EMR) system in an HL7 messaging format using standard LOINC and SNOMED coding.

Continuation of our Utah EHDI Tele-Audiology Project with the goal of providing better and more timely follow-up and consultative audiological services to rural and remote areas of the state will occur. A process will be developed to monitor the quality and completeness of individualized demographic and age-specific data, utilizing our CHARM interface and targeted training with EHDI Hospital Coordinators.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9.1	9.1	8.3	5.9	5.9
Annual Indicator	8.4	6.9	5.9	7.9	7.9
Numerator	71700	59700	51367	69600	69600
Denominator	857680	860368	870623	886110	886110
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	7.9	7.6	7.5	7.5	7.5

Notes - 2012
Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2011
Denominator: IBIS Population estimates 2011

Notes - 2011
Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2011
Denominator: IBIS Population estimates 2011

Notes - 2010
Numerator: The number of children with no insurance calculated using the data from the BRFSS, 2010
Denominator: IBIS Population estimates 2010

a. Last Year's Accomplishments
The Performance Measure was not achieved. The Performance Objective was 5.9% and the Annual Indicator was 7.9%.

The Performance Annual Indicator of 7.9% is a purer reflection of Utah's uninsured children than last year's performance objective of 5.9%. The annual indicator reflects improved data collection methods for the Utah Behavioral Risk Factor Surveillance System (BRFSS), the only method used to calculate Utah's uninsured children's rate. The improved data collection includes the ability to contact that portion of the population served only by cell phones in addition to surveys conducted over land line phones. According to the Utah American Community Survey 2011, Utah's uninsured children's rate is at 11.1%. The 2011 National average of uninsured children is 7.5%. Enrollment numbers gathered for current activities report were provided by the Utah Office of Public Health Assessment, the Center for Health Data and the Utah Behavioral Risk Factor Surveillance System.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Utah BRFSS was the method used to collect data on the number of children without health insurance in Utah.			X	
2. Information for this performance measure included improved methods of capturing information through the Behavioral Risk Factor Surveillance System. The system contacted Utah's population by cell land line telephone.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
For Fiscal Year 2012 we saw an increase in the number of uninsured children in the state of Utah. The annual Indicator rose from 5.9% to 7.9% which reflect improved data collection throughout the state of Utah. The Utah Behavioral Risk Factor Surveillance System (BRFSS) which captures uninsured children's data began conducting surveys to include Utah's population serviced by only cell phones in addition to performing surveys over land line communication. This additional contact source resulted in a broader survey sample showing an increase of Utah's uninsured children. Fiscal Year 2013 BRFSS data will be available in July 2013, but probably not in time to revise before the grant is due. The number of Children insured by Medicaid increased by 3,838 with a total enrollment in February 2013 of 171,597 compared to the February 2012 enrollment of 167,759. Enrollment in CHIP decreased by 1,313. Current February 2013 enrollment of CHIP was at 35,748 compared to February 2012 CHIP enrollment of 37,061. The decline in CHIP enrollment versus increased enrollment into Medicaid is attributed to changes in Medicaid eligibility.

c. Plan for the Coming Year
The vacated position of School Health Consultant was filled in September 2012 by an experienced nationally certified school nurse. Having an experienced school nurse in this position provides the Department new insight to the rigor of expanding efforts to decrease the percentage

of Utah's children without health insurance in the school setting. The school nurse consultant plans to continue with the Departments campaign to promote linkage of services through the expansion of home visiting services and WIC referrals. During a home visit, staff is prepared to introduce families to the application process for Medicaid or the CHIP program via language interpretation assistance.

In addition, this forthcoming school year, efforts to have application information available through the school systems including public, charter and, as requested, private school settings will be pursued. In addition to application information being sent to every school for every Utah child via back pack distribution or in Welcome Back packets, it is proposed to have additional application information available in school front offices, offered through school registration staff, front office personnel, counselors and school nurses. As available, posters advertising CHIP and Medicaid enrollment will be posted in school sites. Specific attention to Title 1 schools to address language barriers will be considered.

In-service on the application process and need to insure Utah's school age children will be addressed during a school nurse conference and through the School Nurse Education Series known as Tele Health.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	21.6	21.8	21.8	20.7	20.7
Annual Indicator	21.8	21.8	20.7	20.7	19.3
Numerator	6558	6558	7083	7083	9967
Denominator	30083	30083	34217	34217	51735
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See Footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	19.1	19.1	18.5	18.5	18

Notes - 2012
WIC SharePoint Ad Hoc Report Child Participation Count, 2012 Data
(Includes infants and 1 year olds at risk in the measure with 2 - 5 year olds)

* CDC no longer provides the data on this measure.

Notes - 2011
The data are from the 2010 CDC Pediatric Nutrition Surveillance, Table 6F (combining the 85th-<95th and greater than or equal to 95th BMI categories).

Notes - 2010
The data are from the 2010 CDC Pediatric Nutrition Surveillance, Table 6F (combining the 85th-<95th and greater than or equal to 95th BMI categories).

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance objective was 20.5% and the Annual Indicator was 19.27%.

The Utah WIC Program continued to collaborate with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) also called SNAPEd and the Food Stamp Nutrition Education Program (FSNE) which is known as the Food Sense Program. WIC children who were at risk of overweight or overweight were referred to these nutrition programs for Healthy Lifestyle classes. During FY 2012, it was determined that 93 of the Healthy Lifestyle classes were taught in the Utah WIC clinics or at an EFNEP or FSNE location. More than 5100 (5,115) WIC participants completed these classes which contained information about healthy eating on a budget, increasing physical activity and healthy recipes/food preparation. The classes which were interactive allowed participants to experience cooking, setting goals to achieve lifestyle changes and enhancing family mealtime. All of the topics were well received by the WIC participants.

The results of the 2010 Utah WIC Program Participant Satisfaction Survey were used to update and revise the Utah WIC Program Authorized Foods List. These results, along with the 2010 Dietary Guidelines, were used to revise 21 nutrition education materials including handouts on Choosing MyPlate, Eating Better on a Budget, Make Half Your Plate Fruits and Vegetables and Screen Time. In addition, more than 8000 National WIC Association (NWA) 2012 calendars were purchased and distributed to Utah WIC families. These calendars entitled, A World of Tastes on MyPlate, were well received by participants and included nutrition education, physical activity tips and healthy recipes. The education focused on the health benefits of fruits, vegetables, whole grains and low fat foods. Each month featured a meal depicted in the MyPlate format with a healthy recipe including the nutrient content for calories, protein, carbohydrate, fat, sodium and fiber per serving. In 2012 4% more WIC participants completed online nutrition education via the wichealth.org computer application. The most popular nutrition lessons completed were Starting Solids, Baby's First Cup, Fruits and Veggies Grow Healthy Kids and Making Meals and Snacks Simple.

Additional nutrition education was provided in the Sesame Street "Food for Thought-Eating Well on a Budget" kits which were distributed to more than 30,000 families in all Utah WIC clinics. The participants were excited to receive the kit information which covered 5 different areas including, 1) Family Food Talk which offers ways for families to talk together about food and any related concerns that families and children may have, 2) Healthy Foods on a Budget contains ideas for families on how to plan, shop, and save money, 3) Healthy Choices Anytime provides tips for children to make healthy choices anytime and anywhere, 4) Making Connections contains ways to reach out for help and support, and 5) Sesame Street Recipe Cards provide healthy recipes. These kits complemented the information in the USDA Fit WIC Program which was provided to all local WIC staff in articles published in the monthly newsletter, WIC Wire. Fit WIC was designed to reduce the prevalence of overweight/obesity in childhood and has demonstrated positive results. The WIC Wire articles covered topics such as, Fit WIC for Staff, Staff Training on Overweight and Obesity in Childhood, Healthy Mealtime Behaviors, Desirable Levels of Physical Activity, Healthy Snacks, Understanding Hunger Cues, Increasing Fruit and Vegetable Intake, Limiting Screen Time, and Decreasing Sugar Sweetened Beverage Consumption.

The Utah WIC Program successfully implemented the new WIC computer system, VISION from July 2011 through October 2011 in all local WIC clinics, allowing for the documentation of comprehensive nutrition assessments/education. There has been a delay in the schedule for implementation of the 2006 WHO growth charts until July 2013. These new growth charts show "how children should grow" and establish breastfeeding as the biological "norm" for measuring

healthy growth. The charts allow standardized Body Mass Index (BMI) charts to be used in the assessments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 93 Healthy Lifestyle classes were taught in WIC clinics or at an EFNEP/FSNE location.		X		
2. 5,100 WIC participants completed Healthy Lifestyle classes.		X		
3. 30,000 "Food for Thought- Eating Well on a Budget" kits were distributed.			X	
4. 8,100 National WIC Association (NWA) 2012 calendars were distributed.		X		
5. 21 nutrition education handouts were updated.		X		
6. The Utah WIC Program Authorized Foods List was updated.			X	
7. USDA Fit WIC Program content was made available to local WIC staff.				X
8. The new WIC VISION computer system was implemented in all local WIC clinics.				X
9.				
10.				

b. Current Activities

All WIC children at risk of overweight/overweight and obese are being referred to the Healthy Lifestyle classes offered by SNAPEd and the Food Sense Program. The Utah WIC Program is offering the new USDA MyPlate resources for use in clinics. The updated Utah WIC Program Authorized Foods List is being used as of October 2012. Articles on the USDA Fit WIC Program continue to be published in the monthly Utah WIC Program newsletter entitled, WIC Wire. The Washington University training module entitled, "Life Course Nutrition: Maternal and Child Health Strategies in Public Health" (http://www.nwcphp.org/training/courses/nutrition) and the University of Tennessee MCH Life Course training are being offered to local WIC staff.

The current Loving Support - A Journey Together Peer Counselor training is being provided for Peer Counselors. In addition, the Utah WIC Program, in collaboration with the developers of wichealth.org., is piloting an Online Peer Counselor (OPC) application. OPC allows breastfeeding participants to access a secure application through the wichealth.org computer portal, enabling them to communicate instantly with Utah WIC Peer Counselors who can provide immediate support for initiation and continuation of breastfeeding which can potentially reduce pediatric overweight/obesity. Also, the new USDA risk definitions for at risk of overweight/overweight and obesity for infants and children are being implemented.

c. Plan for the Coming Year

The Utah WIC Program will continue to collaborate with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) also called SNAPEd and the Food Stamp Nutrition Education (FSNE) Food Sense Program. Parents and caretakers of WIC children who are at risk of overweight/overweight or obese will be referred to nutrition programs for Healthy Lifestyle classes. The Utah WIC Program will continue to integrate MyPlate resources into all applicable nutrition education materials. This MyPlate visual asks the question, "What's on your plate?" and emphasizes plating out half your plate as fruits and vegetables.

Articles on the USDA Fit WIC Program will continue to be published in the WIC Wire. These

articles will provide evidence based strategies on how to implement Fit WIC in the local WIC clinics. Additional obesity prevention resources will be identified, reviewed and considered for implementation. Some of these resources will include the 5,2,1,0 Every Day! Childhood Obesity Messaging campaign, Let's Move and We Can! The 2006 WHO growth charts for birth to 24 months will be implemented during July 2013. These new growth charts show "how children should grow" and establish breastfeeding as the biological "norm" for measuring healthy growth. These charts will allow standardized Body Mass Index (BMI) values to be used in the assessment of healthy weights for infants and children up to 24 months of age. The new USDA definitions for underweight, short stature and high weight-for-length for infants and children < 24 months of age will be based on the 2006 WHO growth standards.

The Utah WIC Program will also offer additional WIC training courses to all local WIC staff. These training courses will enhance nutrition assessment/counseling skills and will include WIC 101, Communicating with Participants, Counseling Skills, Reaching Participants Through WIC, Feeding Infants: Nourishing Attitudes and Techniques and Value Enhanced Nutrition Assessments. In addition, the results of the 2012 Participant Satisfaction Survey will be analyzed and compared to the 2010 survey results for the purpose of noting increases in healthy food selection, as well as overall satisfaction with nutrition services. These results will also be used to revise and update nutrition education materials and the Utah WIC Program Authorized Foods List.

Lastly, the Utah WIC Program will continue to collaborate with the developers of wichealth.org to pilot and implement an Online Peer Counselor (OPC) program in all interested local WIC agencies. Utah WIC participants will be able to access this secure OPC computer application, enabling them to communicate instantly with Utah WIC Peer Counselors who can provide immediate support for initiation and continuation of breastfeeding. This immediate support will, hopefully, encourage longer breastfeeding duration rates which can potentially reduce pediatric overweight.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.2	4	3.8	3.5	3.2
Annual Indicator	3.9	3.6	3.2	3.3	3.3
Numerator	2188	1936	1666	1668	1668
Denominator	55605	53894	52164	51144	51144
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	3.2	3.2	3.1	3	3

Notes - 2012
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011

Notes - 2011
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Notes - 2010
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments
The Performance Measure was not achieved. The Performance Objective was 3.2% and the Annual Indicator was 3.3%.

During 2012, the Utah Department of Health's Tobacco Prevention and Control Program (TPCP) distributed educational brochures and tobacco cessation tools via local health departments. Through TPCP funding a few local health departments (LHDs) offer one- on-one counseling to pregnant women to help them and their family members quit smoking. Most refer pregnant women to the enhanced counseling services offered through the Utah Tobacco Quit Line using a fax referral system. Enhanced services for pregnant women through the Utah Tobacco Quit Line include: additional outbound calls, all calls with the same female coach, unlimited inbound calls, text messages, postpartum coaching calls and nicotine replacement therapy with medical provider consent. From March 1, 2010-December 31, 2012 there were 100 pregnant women that utilized Quit Line services.

During 2012, LHD staff visited private providers' offices to provide consultations regarding incorporation of tobacco cessation materials and messages into their practices. The program also promoted the TRUTH Network Tobacco Cessation Program to the private providers as well as to the WIC Program and LHDs. The TRUTH Network Tobacco Cessation Program includes the Quit Line and the Quit Line fax referral system. LHDs, private providers and WIC offices fax referrals to the TPCP Quit Line for pregnant women interested in receiving support in their cessation efforts. With the implementation of a new computer system at WIC clinics, the Quit Line fax referral process has become more difficult. More training for WIC staff is needed to ensure that this service is being utilized to its full capacity. A few locals have also sought additional funding and resources to serve this important population group. For example, the Utah County Health Department obtained a grant to offer diaper incentives to pregnant women and their spouses that quit and stay tobacco free the months following delivery.

Medicaid offered tobacco cessation to pregnant women through a variety of outreach efforts. During a pregnant woman's initial Medicaid intake, the Department of Workforce Services, the state agency in Utah tasked with determination of Medicaid eligibility, screened women regarding tobacco use. A woman with a positive screen was referred to a Medicaid Health Program Representative (HPR) who, with the consent of the woman, contacted her every six weeks throughout her pregnancy. Medicaid also covered nicotine replacement therapy when prescribed by the woman's health care provider. During FY2012 more than 1,700 (1,717) Medicaid-insured pregnant women received free counseling and prescriptions for medications to help them quit using tobacco. Close to 32% of participants in the TPCP-funded Medicaid program for pregnant women quit using tobacco and 26% reduced their tobacco use.

An article on the effects of tobacco use before, during and following pregnancy was placed on the Maternal and Infant Health Program website, along with a link for health care providers to access educational materials and resources for professionals to aid women in tobacco cessation.

The Maternal and Infant Health Program analyzed Utah Vital Records birth data from 2010 and used the findings to update and publish the IBIS indicator on third trimester smoking so that partners and stakeholders are aware of potential intervention efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Maternal and Infant Health Program (MIHP) placed an article on the effects of tobacco use before, during and after pregnancy on the program's website.			X	
2. The Maternal and Infant Health Program analyzed 2010 Vital Records Birth Data and used the data to update and publish the IBIS indicator on third trimester smoking.				X
3. The Utah Tobacco Quit Line provided quit services to pregnant women that included text messages, postpartum coaching calls and nicotine replacement therapy with medical providers consent.		X		
4. Staff from local health departments visited private providers' offices to provide consultations regarding incorporation of tobacco cessation materials and messages into their practices.				X
5. Department of Workforce Services screened women about tobacco use at Medicaid intake. A smoking mother was referred to her Health Program Representative for tobacco cessation services and called every six weeks during pregnancy to track progress.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The TPCP continues to promote the TRUTH Network's Quit Line fax referral system and integrate this into health systems reaching pregnant women. WIC screens all enrollees for tobacco use. WIC clinics, local health departments and private providers use the system to refer pregnant clients using tobacco to the Quit Line.

The Department of Workforce Services staff refers pregnant Medicaid applicants to HPRs for cessation support via phone calls every six weeks throughout pregnancy. In 2011, the number of Quit Line calls covered by Medicaid for pregnant clients was increased by the addition of a call postpartum to women successful in quitting or reducing tobacco use. TPCP tracks and the number of women using the Utah Tobacco Quit Line enhanced services and evaluates the effectiveness.

The MIHP analyzed 2011 Utah Vital Records birth data, which indicate that 3.3% of women smoked during the last trimester of their pregnancies. The highest rates were noted among 18-19 year-olds (6.6%) and 20-24 year-olds (4.9%). Smoking rates were higher among women who had a high school education (8.8%) or less (6.7%). There are also geographical areas of the state that have much higher rates than the state average: Tri-County (10.4%) and Southeastern (10.0%).

Unmarried women and women with "Other" relationship status were more likely to smoke (10.3% and 21.2%, respectively) in the last three months. These data were used to update and publish the IBIS indicator on third trimester smoking.

c. Plan for the Coming Year

During 2013 the Tobacco Prevention and Control Program (TPCP) will continue to utilize its TRUTH Network Tobacco Cessation Program's Quit Line as a primary source of education and support to pregnant women in their tobacco cessation efforts. The Quit Line fax referral system will continue to provide ready access for local health departments, WIC Offices and private providers to Quit Line services for their clients needing support in their cessation efforts.

The Department of Workforce Services, the state agency responsible for Medicaid enrollment, will continue to screen all enrollees for tobacco use. Pregnant women using tobacco will be referred to Medicaid Health Program Representatives (HPR). With consent of the woman, a HPR will contact the client via phone every six weeks during her pregnancy to support the client's cessation efforts. The woman will also be referred to the TPCP's Quit Line. A woman successful in either quitting or reducing tobacco use will receive an additional phone contact two to three months following delivery to reduce the risk of relapse. Medicaid will continue to provide coverage for nicotine replacement therapy when prescribed by the woman's provider.

The Maternal and Infant Health Program will maintain the article on tobacco use during the perinatal period along with the link for health care providers to cessation resources for professionals on their website. Vital Records and PRAMS data will be utilized to analyze the demographic characteristics of women using tobacco during the third trimester of pregnancy and the IBIS Indicator for third trimester smoking will be updated.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.2	10.6	11	12.1	11.4
Annual Indicator	11.5	12.1	11.4	10.8	10.8
Numerator	25	26	25	24	24
Denominator	216682	215470	219146	221712	221712
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	10.8	10.8	10.8	10.8	10.8

Notes - 2012
Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2011
Denominator: IBIS Population estimates for 2011

Notes - 2011
Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2010
Denominator: IBIS Population estimates for 2010 (GOPB).

Notes - 2010
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Mortality database, UDOH, 2010
Denominator: IBIS Population estimates for 2010 (GOPB).

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 11.4 and the Annual Indicator was 10.82.

The Violence and Injury Prevention Program (VIPP) continued to provide data collection and analysis services on Utah suicides (suicide fatalities, suicide emergency room visits, and suicide hospitalizations) to partners and the media. VIPP also developed a state plan for injury in which suicide prevention is a priority for youth 15 to 19 years of age. Staff participated on the Utah Suicide Prevention Coalition.

VIPP continued to facilitate the state Child Fatality Review Committee (CFRC) in which the Division's Medical Director also attended and participated. The Child Injury Deaths in Utah report was produced which breaks down child deaths by age, sex, geographic location, and circumstances and includes a section on youth suicides. The report also provides recommendations for prevention of these deaths.

VIPP responded to 16 media requests on suicide in FY12 and continued to serve as a primary source of data on suicides across the lifespan.

The Utah National Alliance on Mental Illness (NAMI) continued to provide the Hope For Tomorrow Program, a mental health education program which brings together the combined efforts and insights of mental health professionals, educators, and other experts to help parents, teachers, students and communities understand mental illness.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. VIPP provided data collection and analysis services.				X
2. VIPP developed a state plan for the prevention of suicide for youth ages 15-19.			X	X
3. VIPP co-chaired the Utah Suicide Prevention Coalition.				X
4. VIPP facilitated the Utah Child Fatality Review Committee (CFRC) which reviews all child deaths under age 18 in the state.				X
5. Utah National Alliance for Mental Health continued its Hope for Tomorrow program.		X		
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The Violence and Injury Prevention Program (VIPP) continues to provide data collection and analysis services, utilizing the National Violent Death Reporting System and Child Fatality Databases in this process. VIPP also participated in the development of a plan to prevent suicide among youth ages 15 to 19 and remained co-chair of the Utah Suicide Prevention Coalition. A school health consultant was hired during this fiscal year and serves on the Child Fatality Review Committee and the Utah Suicide Prevention Coalition. Five new fact sheets on suicide across the lifespan (youth, young adult, women, men, and older adults) were produced and disseminated. A news release was also sent to local media in conjunction with the fact sheets' release. This was done in partnership with the Department of Human Services. From July 1, 2012 to March 25, 2013, VIPP has responded to 15 media requests on suicide. VIPP has seen an increasing interest in suicide prevention among stakeholders, the media, and policymakers as evident from the number of data and presentation requests, media stories, and legislation targeting prevention of suicides, in particular youth suicides. VIPP and Department of Human Services Division of Substance Abuse and Mental Health staff gave several presentations on suicide prevention to local school districts and community groups. VIPP also updated the suicide webpages on its website to reflect current trends, circumstances surrounding suicides, and prevention tips.

c. Plan for the Coming Year
VIPP will co-chair the Utah Suicide Prevention Coalition with the Youth Suicide Specialist at the Division of Substance Abuse and Mental Health in the Department of Human Services. VIPP will also participate on the policy subcommittee of the Coalition. VIPP will continue to provide data collection, analysis and fact sheet publication and dissemination to community partners, the media, and policy makers. VIPP will utilize the National Violent Death Reporting System and Child Fatality Databases for data collection and analysis.

VIPP will continue to facilitate the Child Fatality Review Committee (CFRC) which conducts reviews of all child deaths under age 18 in the state. All youth suicides are reviewed in-depth by the CFRC. Recommendations for policy and system changes, education, and interventions are given annually by the CFRC to prevent future deaths.

Many of Utah's 12 local health departments (LHDs) have recognized the growing problem of suicide in their communities. VIPP staff have worked closely with the LHDs to develop activities in their contracts that address youth suicide. Examples of activities the LHDs will undertake in FY14 include participating on their local prevention coalitions, holding youth prevention summits, working with Utah's Native American tribes, implementing the safeTALK program, promoting the National Suicide Prevention Lifeline, engaging community leaders, utilizing local media to de-stigmatize mental illnesses and suicide, attending trainings, etc. VIPP will also leverage funding from a CDC grant to have two staff be trained as Master Trainers for an evidence-based suicide prevention program such as the Question Persuade Refer (QPR) program or Mental Health First Aid.

VIPP hopes to continue efforts to reduce youth suicide, but the extent of involvement will be dependent on resources.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2008	2009	2010	2011	2012

Performance Data					
Annual Performance Objective	84	81	82	80.5	90
Annual Indicator	81.3	78.3	89.8	90.1	90.1
Numerator	469	440	520	499	499
Denominator	577	562	579	554	554
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	90.2	90.3	90.3	90.3	90.4

Notes - 2012
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011

Notes - 2011
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals. Currently there are 10 self-designated level III hospitals.

Notes - 2010
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Facilities for high-risk deliveries and neonates are tertiary Level III hospitals. Currently there are 10 self-designated level III hospitals.

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 90% and the Annual Indicator was 90.1%.

The Healthy People 2020 Target for this objective is 83.7%. Utah had a total of 554 very low birth weight infants (VLBW) in 2011 (latest year for which data are available) with 499 of these infants being born in one of the ten self-designated Level III facilities.

Currently, Utah regulations that designate Levels of Care for Perinatal Services are imprecise and there is no regular oversight of NICU services by the Department. The Utah Administrative Code R432-100-17 on Perinatal Services provides that each hospital shall self-designate its capability to provide perinatal care in accordance with levels described in the Guidelines for Perinatal Care, Seventh Edition.

The Maternal and Infant Health Program (MIHP) carried out a survey of all delivery hospitals in 2009 to obtain objective criteria on which to determine Levels of Care. Based on findings we realized that there were several self-designated NICUs that did not meet the proposed guidelines published in the American Academy of Pediatrics (AAP) Policy Statement for Levels of Neonatal Care, 6th edition. As a result, the MIHP convened a group of over 40 Utah stakeholders of neonatal care in May of 2011 due to concern over the percentage of VLBW infants that were being not being delivered at facilities appropriate for their care. Presentation of the AAP Policy guidelines was made and discussed, as were data on VLBW deliveries in Utah. This large group of stakeholders agreed that a workgroup should be formed to review the issue in detail and to make recommendations on Utah specific guidelines. The workgroup consists of interested individuals, primarily neonatologists from the various health care systems that self-designate as Level III NICUs, to reach agreement on Utah guidelines for Perinatal Services, specifically around Levels of NICU care.

The workgroup met quarterly during 2012 and discussed many issues relevant to appropriate care for VLBW infants in Utah. Presentation of birth and death certificate data analyses of VLBW births and deaths by gestational age and hospital of delivery were made to illustrate variation in infant mortality rates by facility. In addition, results from an examination of cases of VLBW infants born outside of level III facilities to determine appropriateness of decision showed that 90% of infants were born in Level IIIs and among those who were not, the decision was deemed appropriate (pre-viable, imminent delivery, maternal risks for transport, known lethal congenital anomaly). The workgroup spent much time discussing the need for consensus-driven Utah Perinatal (Neonatal) Guidelines and pertinent literature was reviewed on the following topics: VLBW delivery site and outcomes, hospital volume and neonatal mortality among VLBW infants, perinatal re-regionalization and the new AAP Guidelines released 10/2012. One issue that was identified during the workgroup discussion was the need for parental input about their NICU experiences, satisfaction, and factors that went into their decision on where to delivery their VLBW infant.

The workgroup discussed the use of the Hospital Discharge Data set to examine VLBW morbidities and determined that since these are billing data they are not ideal for making determinations of morbidities. The workgroup agreed upon the need to submit Vermont Oxford/Pediatrix data elements for severe morbidities to the UDOH to help guide collaborative learning discussions and improve the quality of NICU care. The need for an Administrative Rule to allow and protect hospitals submitting morbidity data to the Department was defined and will establish reporting requirements for certain VLBW infant morbidities (and associated maternal data), and newborn care capabilities in Utah. The rule has been developed and vetted with workgroup participants and high level stakeholders and modified based on feedback.

Although much good work has taken place in the workgroup, the development of Utah Perinatal Guidelines was stalled awaiting release of 7th edition of Guidelines for Perinatal Care (October 2012).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH convened a Workgroup, primarily neonatologists from the various health care systems that self-designate as Level III NICUs, to reach agreement on Utah guidelines for Perinatal Services, specifically around Levels of NICU care.				X
2. MCH presented birth and death certificate data of VLBW births and deaths by gestational age, hospital of delivery to workgroup.				X
3. MCH reviewed cases of VLBW infants born outside of level III				X

facilities to determine appropriateness of decision.				
4. MCH reviewed various other states' Guidelines for Perinatal Care documents (Michigan, Washington, Arizona).				X
5. Literature was reviewed including: VLBW delivery site and outcomes, hospital volume and neonatal mortality among VLBW infants, perinatal re-regionalization, new the AAP Guidelines released 10/2012.				X
6. The workgroup identified the need for parental input about their NICU experiences, satisfaction, and factors that went into their decision on where to delivery their VLBW infant.				X
7. The workgroup discussed using Hospital Discharge Data set regarding VLBW morbidities and identification of needs to assess outcomes of VLBW infants. The workgroup suggested submission of VON/Pediatrix data elements for severe morbidities to UDOH.				X
8. The workgroup identified the need for an Administrative Rule to allow and protect hospitals. Submitting morbidity data to the Department thereby that establishes reporting requirements for certain VLBW infant morbidities, and newborn care in Utah.				X
9. MCH developed draft Utah Neonatal Guidelines for Neonatal Care.				X
10.				

b. Current Activities

UDOH staff from the Maternal and Infant Health Program and the Neonatal Follow-up Program has collaborated to develop and implement a survey to gather information from parents on their experiences with the NICU facilities that cared for their infants after birth. The purpose of the survey is to secure better understanding of parental knowledge regarding NICU services. Parents of children born prematurely who had been invited to enroll in the Neonatal Follow-up Program at the Utah Department of Health participated in the survey and we are awaiting return and analyses of those data.

The Neonatal Workgroup participants have agreed on next steps which include the establishment of an ongoing statewide Neonatal Quality Improvement Collaborative described as a multi-stakeholder network comprised of neonatal partners from Utah's ten self-designated Level III NICUs. The Collaborative will subsume this Workgroup and continue to meet regularly to employ a quality improvement framework utilizing facility specific morbidity and care data to work toward quality improvement in neonatal care in Utah.

Draft Guidelines for Neonatal Care based on the Seventh edition of the AAP/ACOG Guidelines for Perinatal Care have been developed and are currently being reviewed for input from stakeholders.

c. Plan for the Coming Year

The Neonatal Quality Improvement Collaborative will continue to meet quarterly. Work will continue to complete Utah Guidelines for Neonatal Care based on the 7th edition of Guidelines for Perinatal Care that was recently published. While many of the criteria outlined in the most recent AAP/ACOG publication are well defined, there are certain issues that leave room for interpretation, most notably, availability of pediatric medical subspecialists and pediatric surgical specialists. The Guidelines indicate that Level III NICUs are defined by having "continuously available" personnel (neonatologists, neonatal nurses, respiratory therapists) which has been the crux of disagreement among the ten Utah self-designated NICU stakeholders. We are currently at an impasse in our development of Utah-specific Guidelines. The term "continuously available" is

open for different interpretations, such as available within a certain time frame, available by phone, or in hospital.

Another contentious issue cited in the AAP/ACOG Guidelines is patient volume. The Guidelines indicate that designation of Level III care should be based on "clinical experience as demonstrated by large patient volume", among other things. In Utah, NICU care has been gradually moving away from a regionalized system with the opening of numerous community-based NICUs with a relatively small volume of VLBW patients per year.

These contentions have led to the development of the VLBW Reporting Administrative Rule. The rule establishes reporting requirements for certain Very Low Birth Weight (VLBW) infant morbidities and newborn care capabilities in Utah. The rule will be adopted through the process outlined in the state Administrative Rules process. The Neonatal Quality Improvement Collaborative will utilize facility-specific morbidity and care data obtained through the Rule to help identify variations in outcomes and make evidence-based decisions on how NICU care is delivered in Utah.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	78.6	79	79.1	71.7	73.1
Annual Indicator	79.1	71.6	73.1	74.7	74.7
Numerator	43977	38562	38124	38228	38228
Denominator	55605	53894	52164	51144	51144
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	74.9	75	75.2	75.9	76

Notes - 2012
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011

Notes - 2011
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Notes - 2010
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments
The performance measure was achieved during 2012. The Annual Performance Objective was 73.1 % and the Annual Indicator was 74.8% in FY 2012.

Using data from the past three years collected by the revised birth certificate we are able to see improvement in the number of Utah resident mothers entering into prenatal care during the first trimester of pregnancy. The 2012 indicator is up from 73.1% in FY2011.

During FY12, Baby Your Baby (BYB) applications were submitted via paper and Utah Clicks, an online application system that permits women and families to apply for BYB and services from Baby Watch, Children with Special Health Care Needs, Early Head Start and Head Start. In FY12, 4,744 applications were submitted to BYB via Utah Clicks compared to the 5,070 from FY11. This decrease may reflect the loss of funding for media outreach for a period of time.

The Maternal and Infant Health Program (MIHP) continued to support "Text4Baby", a campaign sponsored by the National Healthy Mothers, Healthy/Babies Coalition. BYB began placing "Text4Baby" information in all Keepsake booklet mailings. Utah has 3,718 mothers enrolled into the "Text4Baby" Program. However, Utah's enrollment rates continue to be among the lowest in the nation.

BYB and radio B98.7 hosted "Operation Baby Bundle" in 2011 to support the March of Dimes Teddy Bear Den, a prenatal health program for low income pregnant women. A second Teddy Bear Den was opened in Cedar City in March 2012.

MIHP participated on the Office of Health Disparities Reduction's Birth Outcomes Advisory Board to support development of culturally appropriate health brochures and videos for Latino, Pacific Islander and African American communities. The videos encourage early prenatal care, folic acid, healthy diets and weight and are linked on the MIHP website. There are clear disparities in early entry into prenatal care in these populations. Only 48.8% of Pacific Islander mothers report entering prenatal care in the first trimester (Utah Vital Records, 2010). There is a positive trend for Hispanic women entering into early prenatal care reaching 63.1% in FY 2012, up from 57.3 in FY2010, and 60.2% in FY 2011.

The Maternal and Child Health Bureau provided funding to support the Salt Lake Community Health Centers, Inc. in providing early and continuous prenatal care for under and uninsured women in their clinics throughout Salt Lake County.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Baby Your Baby and radio B98.7 hosted "Operation Baby Bundle" in June 2012 to support the March of Dimes Teddy Bear Den, a prenatal health program for low income pregnant women.			X	
2. The Maternal and Infant Health Program (MIHP) continued to support "text4baby", a campaign sponsored by the National Healthy Mothers, Healthy/Babies Coalition, by posting a link on the MIHP website to the campaign's website.			X	
3. Baby Your Baby began placing "text4baby" information in all Keepsake mailings.			X	
4. A second Teddy Bear Den was opened in Cedar City in March 2012.		X		

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In an effort to improve reporting of entry into prenatal care on birth certificates, the MIHP is collaborating with the Utah Office of Vital Records and Statistics to promote further training of hospital personnel involved in completion of birth certificates.

The MIHP is educating local health departments, community health centers, hospitals and other appropriate agencies about BYB and the national "Text4Baby" campaign. The MIHP will continue to provide funding for under/uninsured women seeking prenatal care via the Salt Lake Community Health Centers, Inc.

BYB and our partners at Intermountain Healthcare's Intermountain Moms have launched a new media campaign which involves monthly segments on KUTV beginning in March of 2013 to discuss pregnancy and prenatal care.

BYB is working to increase its presence on Twitter, Pinterist, Vine, Tumbler, Instagram and a BYB Blog.

UDOH is sponsoring the Utah Bees and BYB information will be announced over the PA and in the programs at several home games.

BYB is also partnering with Simmons Media to conduct radio segments and advertisements on pregnancy stories on 5-different stations in Utah.

c. Plan for the Coming Year
In an effort to improve reporting of entry into prenatal care on birth certificates, the MIHP will collaborate with the Utah Office of Vital Records and Statistics to promote further training of hospital personnel involved in completion of birth certificates, including validation studies that examine self-report and reporting prenatal care on birth certificates. Pregnancy Risk Line will also increase surveillance by asking callers about the timing of entry into prenatal care. The Pregnancy Risk Line will survey more than 20% of callers and will ask several questions regarding type of insurance for coverage of pregnancy and caller level of education. They will also query women about barriers to early care.

MIHP will continue to assess its role in the ensuring access to prenatal care through Medicaid, Community Health Centers (CHC), and connecting individuals to available resources as well as helping potential mothers navigate the Affordable Care Act (ACA) as it rolls out.

The MIHP will continue to track reasons for late prenatal care entry using Utah PRAMS data and disparities in early entry to prenatal care. Using results, messages will be developed to increase the awareness of the importance of early and continuous prenatal care and a "PRAMS Perspectives" report will be created for moms and providers.

Education will continue to be a focus with the aim of reducing population disparities in the percent of women entering early prenatal care by FY 2015. MIHP will continue to track reasons for late prenatal care entry using Utah PRAMS data. Using results, messages will be developed to increase the awareness of the importance of early and continuous prenatal care.

BYB plans to continue to promote their services and accept applications via phone and online. "Text4Baby" will be actively promoted on social media outlets such as Facebook and Twitter alongside "Power Your Life" and the national preconception campaign that will launch in October 2013.

The MIHP will continue to provide funding for under/uninsured women seeking prenatal care via the Salt Lake Community Health Centers, Inc. as resources allow. Throughout FY14 commercials encouraging women to seek early and adequate prenatal care will continue on KUTV (CBS) as well as on all Simmons Media radio stations.

KUTV will continue to air its 2-minute segments and news stories featuring information that pregnant women need to know to have a healthy pregnancy. During FY14 we are hoping to increase the frequency of BYB story television spots from monthly to weekly. Although the rates of early entrance into prenatal care are improving, differences among population groups exist. Women under 25 years of age are significantly less likely to enter into prenatal care during their first trimester. During the FY2014 UDOH and MIHP will initiate campaigns targeting these younger women.

D. State Performance Measures

State Performance Measure 1: *Percent of women of reproductive age (18-44 years) who report that they take a multivitamin pill or supplement containing at least 400mcg of folic acid daily.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				38	37.6
Annual Indicator			37.6	37.6	37.6
Numerator			52274	52274	52274
Denominator			138948	138948	138948
Data Source		See footnote	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	37.7	37.7	37.9	38	38.2

Notes - 2012
Data based on Utah Behavioral Risk Factor Surveillance System, 2010
Utah BRFSS 2012 data are not yet available

Notes - 2011
Data based on Utah Behavioral Risk Factor Surveillance System, 2010
Utah BRFSS 2012 data are not yet available

Notes - 2010
This is one of the new SPMs identified during 2010 Needs Assessment . Data based on Utah Behavioral Risk Factor Surveillance System, 2010

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 37.6% and the Annual Indicator was 37.6%.

The Utah Birth Defect Network (UBDN) continued it monitoring of the occurrence of all major structural malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Neural tube defects (NTDs) are monitored closely since congenital malformations are responsive to public health intervention with folic acid. From 1994 through 2009, 584 (7.6 per 10,000 births) affected cases occurred in Utah.

In January the 2012 BRFSS statewide telephone survey began to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid. The folic acid questions were added to the landline survey (5000 respondents) as well as the cell phone survey (1250 respondents).

Birth Defect Prevention Month packets were sent to OB/GYN offices with messages about heart defects, folic acid and preconception health with the focus for the campaign on congenital heart defects.

Of the non-pregnant and breastfeeding callers to the Pregnancy Risk Line, only 26% were consuming a vitamin with folic acid. Those not taking a vitamin were educated on the importance of folic acid. As part of the Pregnancy Risk Line breastfeeding survey, 18.3% of the non-pregnant callers mentioned they were taking a multivitamin; 35% responded that they would like a free bottle and were mailed multivitamins containing folic acid. Pregnancy Risk Line used social media to send messages on the importance of folic acid.

Message send: Got FolicAcid? Taking a multivitamin with 400 mcg of folic acid- right now- protects your future babies. Read more at http://www.poweryourlife.org

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. BDN monitored the occurrence of neural tube defects.			X	
2. BDN promoted Birth Defect Prevention Month and Folic Acid Awareness week.			X	
3. PRL reached an increased number of non-pregnant and breastfeeding callers who were counseled regarding folic acid.			X	
4. BDN and PRL incorporated use of social media to promote folic acid use.			X	
5. BDN and PRL promoted the use of folic acid at community events.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The tracking of neural tube defect (NTDs) occurrence is crucial in planning, carrying out, and assessing folic acid programs to reduce preventable cases. From 1994 through 2010, 615 (7.5 per 10,000 births) affected cases occurred in Utah.

In the spring of 2013, the UBDN will request that the folic acid module be added to the 2014 BRFSS statewide telephone survey to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid.

Birth Defect Prevention Month 2013 theme was "Birth Defects are Common, Costly, and Critical". The UBDN was a major contributor to the success of the month's activities National and Internationally, as we created a PSA with the theme of "Birth defects affect us all. What effect will you have on birth defects?" View the PSA at www.youtube.com/NBDPN. UBDN working with many agencies disseminated over 4000 bottles of vitamins.

Non-pregnant, and breastfeeding callers to the PRL are continuing to be asked about multivitamin with folic acid. Those callers not consuming a vitamin with folic acid are educated on the importance of the vitamin. As part of the PRL's breastfeeding survey, non-pregnant callers are asked about taking a multivitamin.

Facebook and Twitter messages continue to be posted on the importance of taking folic acid for women of childbearing age. Message sent: Got #FolicAcid? Taking a multivitamin with 400 mcg of folic acid right now protects your future babies.

c. Plan for the Coming Year

The Utah Birth Defect Network will continue to monitor the occurrence of all major structural malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Specifically, neural tube defects (NTDs) will be monitored closely since these congenital malformations are responsive to public health intervention with folic acid.

The Utah Birth Defect Network will make the request for the folic acid question to be put on the 2014 BRFSS statewide telephone survey to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid.

Activities will be planned around January Birth Defect Prevention Month and Folic Acid Awareness week for 2014.

Pregnancy Risk Line will continue to counsel non-pregnant, and breastfeeding Pregnancy Risk Line callers regarding the importance of taking folic acid prior to conception.

State Performance Measure 2: *The percentage of Primary Cesarean Section Deliveries among Low Risk women giving birth for the first time.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				17	17
Annual Indicator		17.8	17.6	16.9	16.9
Numerator		2695	2566	2410	2410
Denominator		15150	14581	14244	14244
Data Source		See footnote	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	16.9	16.8	16.8	16.7	16.7

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011

Notes - 2011
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Notes - 2010
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments
The annual performance objective was 17.0, and the annual indicator is 16.9, thus meeting the objective.

According to the CDC's National Vital Statistics Reports, vol 61, number 1 (August 28, 2012), 32.8% of all deliveries in the United States are by Cesarean section. The Maternal and Infant Health Program (MIHP) continued to track the number of primary cesarean deliveries to low risk women giving birth for the first time, since a number of experts have recommended decreasing this category of cesarean sections to more rapidly impact the overall number of cesarean births in this country. Since labor inductions may contribute to the increase in cesarean births, the program decided to track the indications for and numbers of elective labor inductions as well.

MIHP maintains several indicators on the Utah Department of Health Indicator-Based Information System for Public Health (IBIS-PH) website. The MIHP added an indicator on the percentage of primary cesarean deliveries among low-risk first birth women.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MIHP tracked rate of primary cesarean section deliveries among low risk women giving birth for the first time, using Office of Vital Records and Statistics birth certificate data				X
2. MIHP tracked rate of elective labor inductions to assess any correlation with rate of cesarean delivery using birth certificate and PRAMS data.				X
3. MIHP updated IBIS-PH with current cesarean section delivery rates for low risk women giving birth for the first time.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Birth certificate data continue to be analyzed to track rates of Cesarean birth among low risk primigravidas. Rates of elective labor induction are being tracked through birth certificate and PRAMS data. Due to a change in PRAMS operations at the CDC level during FY 2013, weighted data have been delayed. A PRAMS Perspective report on comparison of reasons for labor induction between PRAMS and birth certificate data with 2011 Cesarean data is planned for the end of FY2013 or early FY2014. The IBIS-PH indicator on cesarean birth was updated during FY2012. The Maternal and Child Health Bureau (MCHB) in the Utah Department of Health continues to work toward the establishment of a statewide perinatal quality improvement collaborative. Several meetings have been held with a varied group of neonatal care

stakeholders, and this group has begun the process of morphing into a larger organization which will include maternal health quality measures, called the Utah Women and Newborn Quality Collaborative (UWNQC). The Collaborative will be a statewide, multi-stakeholder network dedicated to improving perinatal outcomes. Decreasing rates of repeat and primary Cesarean delivery may be among the first outcome indicators selected by the maternal arm of the UWNQC. A UWNQC strategic plan is being finalized and an organizational chart is being developed. Partners include the Utah Department of Health, U of U Health Sciences Center, Intermountain Healthcare, and the March of Dimes.

c. Plan for the Coming Year

The MIHP will continue to track numbers of primary cesarean birth among low risk primigravidas, and rates of elective labor induction, and to follow for correlations. With new MIHP staff in place, and availability of the delayed PRAMS data, the MIHP will be able to evaluate PRAMS and birth certificate sources for consistency of data related to indications for cesarean delivery.

The IBIS-PH indicator on cesarean births to low risk women giving birth for the first time will be updated annually.

The possibility of incorporating some perinatal quality indicators into Medicaid's quality improvement activities will be explored since the Medicaid reorganization taking place in FY2012 is now complete.

The American College of Obstetricians and Gynecologists (ACOG) has just released two new Committee Opinions (Number 559, April 2013), Cesarean Delivery on Maternal Request and Non-medically Indicated Early-Term Deliveries (Number 561, April 2013). The MIHP will consider ways to get information from these documents out to health care providers and the general public in FY2014.

State Performance Measure 3: *The percentage of live births born before 37 completed weeks gestation.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				9.7	9.7
Annual Indicator		9.8	9.5	9.4	9.4
Numerator		5272	4957	4830	4830
Denominator		53894	52164	51144	51144
Data Source		See footnote	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Provisional
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	9.4	9.4	9	8.5	8

Notes - 2012
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2011

Notes - 2011
Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

Notes - 2010
This is one of the new SPMs identified during 2010 Needs Assessment

Numerator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database, UDOH, 2010

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 9.7% and the Annual Indicator was 9.4%.

Utah continued to rank better than the nation as a whole for preterm births. While as a state we were below the Healthy People 2020 goal of 11.4% for preterm births, there were subpopulations in Utah that had higher rates. In 2011, Utah women of Pacific Islander descent had a preterm birth rate of 12.7%; Black women had a rate of 17.3% and Asian women 11.3%. In addition, women who were enrolled in Medicaid during their pregnancy, which can be used as a proxy for SES, had a preterm birth rate of 10.5%. Another common risk factor for preterm birth is maternal age. In 2011, teens aged 15-19 had a preterm birth rate of 10.8% and women ages 35-44 had a rate of 11.6%.

Because being overweight or obese raises a woman's risk for preterm birth, the MIHP continued to collaborate with the Physical Activity, Nutrition and Obesity (PANO) program to implement strategies developed in the Utah Nutrition and Physical Activity plan. Specifically, MIHP staff continued to participate in the PANO Health Care Work Group, which worked to educate providers on calculating a patient's body mass index at visits and counsel those who are not at an optimal weight.

The MIHP continued to educate providers and women at risk for recurrent preterm birth on the use of 17 alpha hydroxyprogesterone. Downloadable educational materials were made available on our website for distribution and were also shared with local health departments and other community partners on request.

The MIHP brochure on the danger signs of pregnancy, geared towards helping women understand the signs and symptoms of preterm labor or other complications, was also downloadable on our website and shared with community partners on request.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MIHP staff collaborated with staff from the Physical Activity, Nutrition and Obesity (PANO) program to educate providers on calculating a patient's body mass index at visits and counseling women who are not at an optimal weight.				X
2. The MIHP continued to educate providers and women at risk for recurrent preterm birth on the use of 17 alpha hydroxyprogesterone.				X
3. The MIHP continued to make available a brochure on the danger signs of pregnancy, geared towards helping women understand the signs and symptoms of preterm labor or other complications.			X	
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Utah committed to joining the Association of State and Territorial Health Officers (ASTHO) and the March of Dimes (MOD) challenge to reduce our PTB rate by 8% by 2014 using 2009 as the baseline. Utah's PTB goal for 2014 is 8.9%.

In November 2012, the UDOH partnered with the MOD to hold a Prematurity Symposium. There were four goals for the symposium: 1) Encourage collaboration for the prevention of PTB, 2) raise awareness of the scope of the problem, 3) identify specific characteristics and consequences associated with PTB, and 4) identify the areas of focus and make recommendations for interventions. Day two of the symposium gathered key stakeholders to develop actionable recommendations for PTB reduction. The four strategies identified were: 1) Optimization of inter-pregnancy interval, 2) Early identification and treatment of high-risk pregnant women, 3) Increasing the use of progesterone supplementation during high risk for PTB pregnancies to reduce recurrent PTBs, and 4) Increasing single embryo transfers for in vitro fertilization to reduce selective multiple gestations and resultant PTBs. A Utah Health Status Update was published in Feb. 2013 outlining the ASTHO challenge and the recommendations from the Prematurity Symposium.

The UDOH entered into a partnership with the University of Utah to submit a Strong Start application to the Centers for Medicare and Medicaid. Utah's application was not funded, however many of the strategies identified will move forward.

c. Plan for the Coming Year
Utah has committed to joining the Association of State and Territorial Health Officers (ASTHO) and the March of Dimes (MOD) in a partnership aimed at preventing preterm birth (PTB) and infant mortality. The partnership was created to support ASTHO's Healthy Babies President's Challenge and the MOD's Prematurity Campaign. Utah has set a goal to reduce our rate of PTB by 8% by 2014 using the 2009 rate as a baseline. This reduction is reflected in our MCH Block grant projected performance objectives for this indicator. Utah's 2009 rate of PTB was 9.7%; an 8% reduction would mean that by 2014 our PTB rate would not exceed 8.9%.

The Utah Department of Health has recently undertaken a strategic planning process with one of four goals being the "Healthiest People-The people of Utah will be the healthiest in the country." One of the key strategies highlighted under this goal is to "focus efforts on women to achieve healthier pregnancies and births". As part of this initiative, work will continue to promote optimal preconception/interconception health among reproductive aged women. The UDOH will continue to promote the "Power Your Life" social media campaign to promote healthy lifestyles and adequate birth spacing. The MIHP will produce a report on preconception health among reproductive age women in Utah. This document will report on the core preconception health indicators and will be a collaborative effort between the MCH Bureau and the Bureau of Disease Control and Prevention. In addition to these efforts, a second summit on prematurity prevention, sponsored by the UDOH and the MOD, will be held on October 14, 2013 and will focus on preconception/interconception care to prevent PTB.

The Utah Chapter of the MOD, the Utah Department of Health, the University of Utah Health Sciences Center, and Intermountain Healthcare are coordinating the formation of the Utah Perinatal Quality Collaborative (UPQC) to improve perinatal and neonatal service quality in Utah. The UPQC will be a statewide, multi-stakeholder network dedicated to improving perinatal outcomes in Utah. Areas of focus will be determined by UPQC membership; however quality improvement projects related to PTBs, neonatal morbidities and implementation of the 10 Steps

to Successful Breastfeeding will be among the top priorities.

The MIHP and Vital Records will partner with faculty from the University of Utah to conduct a study to validate specific data elements on the birth certificates of preterm infants and assess the feasibility of collecting additional data for a new PTB classification system. All births and fetal deaths less than 34 weeks' gestation from January - March 2012 will be reviewed.

The MCH Bureau is surveying parents of NICU graduates to assess their knowledge around PTB recurrence and provider education they received around prevention of future PTBs. Survey data will be analyzed to look for potential interventions and assess the need for provider education.

State Performance Measure 4: *The percentage of Medicaid eligible children (1-5) receiving any dental service.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				39	37.2
Annual Indicator			37.5	37.2	39.1
Numerator			32945	33907	35396
Denominator			87885	91229	90431
Data Source		See footnote	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	39.5	39.7	40	40.5	42

Notes - 2012
Numerator: Medicaid CMS 416, FFY2012
Denominator: Medicaid CMS 416, FFY2012

Notes - 2011
Numerator: Medicaid CMS 416, FFY2011
Denominator: Medicaid CMS 416, FFY2011

Notes - 2010
This is one of the new SPMs identified during 2010 Needs Assessment.

Numerator: Medicaid CMS 416, FFY2010
Denominator: Medicaid CMS 416, FFY2010

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 37.2% and the Annual Indicator was 39.1%.

The Oral Health Program (OHP) worked closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. The educational video "A Healthy Smile for a Healthy Baby" was distributed to dentists, physicians and other health care providers. We continued to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. Oral health education materials were posted on the OHP website and are being promoted.

The OHP collaborated with staff in Medicaid to expand current EPDST (CHEC) outreach

programs and promote the CHEC dental case management system. In addition, the OHP worked with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an enhanced benefit procedure during CHEC well child exams.

The OHP continued to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services by identifying and eliminating barriers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OHP supported the Utah Oral Health Coalition in educating the medical and dental provider community in an awareness campaign emphasizing the benefits of early and regular dental visits.				X
2. OHP collaborated with Health Care Financing in promotion of the CHEC Dental Case Management Project.		X		
3. OHP worked with Utah Dental Association Access Committee in advocating and promoting early childhood caries prevention and intervention programs and the promotion of increased participation from dentists willing to treat Medicaid patients.				X
4. OHP promoted oral health training and education in Head Start, Early Head Start and WIC programs.				X
5. OHP provided information to UDA and UOHC for their discussions with state legislators.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program (OHP) is working closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. The Oral Health Program continues to provide statewide training and education to all twelve Head Start Programs. Training and education are also given to WIC and local health department staff. We continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. Oral health education material is posted on the OHP website and is being promoted.

The OHP collaborates with staff in Medicaid to expand current CHEC outreach programs and promote the CHEC dental case management system. In addition, the OHP works with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an enhanced benefit procedure during CHEC well child exams.

The OHP continues to work closely with the Utah Dental Association and the Utah Oral Health Coalition to increase the number of dentists willing to see Medicaid patients so that more individuals can be served and barriers reduced.

The Program works to encourage early dental visits and to promote oral health care as an

important part of a young child's daily routine.

c. Plan for the Coming Year
The Oral Health Program (OHP) will work closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. We will continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. The oral health education material posted on the OHP website will be updated and further promoted.

The OHP will collaborate with staff in Medicaid to expand current CHEC outreach programs and promote the CHEC dental case management. In addition, the OHP will work with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an optional procedure during CHEC well child exams.

The OHP will also continue to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients. The OHP will trend utilization data from the Medicaid 416 report to help identify counties and local health departments which may need additional technical assistance to address access to dental care for children. The OHP will continue to work with Head Start and WIC programs for training and education this year. The OHP will continue to seek to identify grants to fund projects which will improve oral health care for underserved children.

State Performance Measure 5: *The percentage of primary care providers/medical homes that conduct routine age-specific developmental screenings in their practice.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				0	0
Annual Indicator					70.2
Numerator					80
Denominator					114
Data Source		See footnote	See footnote	See footnote	See Footnote
Is the Data Provisional or Final?					Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	70.2	70.2	70.2	70.2	70.2

Notes - 2012
Utah Developmental Screening Survey 2012

Notes - 2011
State will be implementing a developmental screening survey during summer, CY 2012. Based on the survey results, projections will be set in future for this measure.

Notes - 2010
This is a new SPM identified during 2010 Needs Assessment. State is currently working on developing a new survey tool as a data source for this measure. As a result, no projections are set for this measure.

a. Last Year's Accomplishments
The performance measure was to increase the percentage of primary care providers that conduct routine age-specific developmental screenings in their practice. No data were available to set objectives last year. This State Performance Measure was established in FY2011 based on the MCH Needs Assessment.

A survey was developed for pediatric and family practices that provide well child care for children birth to 6 years to determine their awareness of existing policies and the use of standardized developmental screening tools in assessing their patient's development. Utah Medicaid continued to bundle the well child check and developmental screening codes. Survey questions were developed to assess if unbundling these codes would change primary care providers' current method of providing developmental screening.

The state's ECCS grant provided funding to the "Help Me Grow" (HMG) program which implemented the first phase of its statewide expansion plan with outreach into Salt Lake County. The DFHP Medical Director was the Pediatric Champion for this expansion. Help Me Grow is a resource and referral program that has been successful in creating an integrated child and family referral service. The Program incorporated the use of the ASQ (Ages and Stages Questionnaire), a standardized developmental screening tool, with families. Help Me Grow distributes ASQs to all parents of young children who enroll in the HMG program. HMG helped parents score the questionnaire and shared the results with the child's medical homes.

Help Me Grow connected more than 1300 families to over 800 resources and has administered 1573 ASQs in the previous three years. As a result of HMG's expansion activities, to date over 200 families were enrolled in HMG in Salt Lake County. The Help Me Grow call center noted an increase in volume and had over 600 active families (families that are in the process of care coordination to resources or child monitoring).

The Bureau of Child Development's Parent Support Programs Manager presented training on developmental screening using the ASQ to Utah's local health departments. To date, 10 of the 12 local health departments have implemented ASQ screening as part of their targeted case management and have conducted over 1,000 ASQ screenings.

In August of 2012 the training of early care and education providers on developmental screening using the ASQ was officially turned over to Utah's six Child Care Resource & Referral Agencies (CCR&R). This training, which was developed and piloted by the Bureau of Child Development, was incorporated into the statewide Career Ladder Training Program for early care and education providers, which is administered through the CCR&Rs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A survey was developed for pediatric and family practices that provide well child care for children (0-6) to determine their awareness of policies and the use of standardized developmental screening tools in assessing their patient's development.				X
2. The Bureau of Child Development funded the Help Me Grow (HMG) expansion into Salt Lake County. HMG engaged parents in developmental screening and sets results to the child's health care provider.				X
3. Local health departments were trained in the use of the Ages & Stages Questionnaire as part of targeted case management. To date, 10 of the 12 local health departments have conducted a				X

combined total of over 1,000 ASQ screenings.				
4. Training of early care and education providers in developmental screening using the Ages & Stages Questionnaire was handed over to the state's Child Care Resource & Referral Agencies and incorporated into the states Career Ladder Program.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The UDOH 2012 Developmental Screening Survey has been distributed to UAAP and UAFP members. Of those who responded, 88% were aware of the AAP policy on the use of standardized developmental screening tools but only 70.2% were using one in their practice.

We are continuing the expansion of HMG in Salt Lake County. The Medical Director is the pediatric champion for HMG and works closely with the efforts being made around developmental screening.

Early Childhood Utah (ECU) focuses on the importance of developmental screening utilizing evidence-based tools. The Medical Director continues to co-chair the Access to Health Care and Medical Homes Subcommittee of ECU funded through the ECCS grant. Increasing the percentage of children who receive a developmental screening is the first objective for this subcommittee's Strategic Action Plan.

To date, no progress has been made with Medicaid and unbundling the well child check and developmental screening codes. Medicaid has been focused on ACO development and health care reform. The survey indicated that 79% of pediatricians indicated that they would be more likely to implement a developmental screening tool into their practice if the codes were unbundled.

The Parent Support Programs Manager is continuing to work with Utah's local health departments on the use of the ASQ in targeted case management. Utah's local CCR&R agencies are continuing to offer periodic Career Ladder training on developmental screening using the ASQ.

c. Plan for the Coming Year
The UDOH Developmental Screening Survey will be distributed every 5 year to family practice and pediatric practices to assess change from baseline, in awareness of existing policies and the use of standardized developmental screening tools in assessing their patients' development.

Results of the 2012 developmental screening surveys, specific to unbundling of codes, will be shared with Medicaid. We will continue to work with Medicaid to discuss opportunities for unbundling.

An article will also be submitted to the Utah Chapter of the AAP newsletter summarizing the results of the developmental screening survey.

The Division will continue to work closely with the Help Me Grow staff to maximize the number of children's health care providers who receive the ASQ (Ages and Stages Questionnaire) results,

and will assist in the follow-up process to assure early and appropriate referrals are made. HMG will be meeting with directors of the pediatric residency program at the University of Utah to establish a HMG curriculum for residents.

The Division will also work with the Help Me Grow Program to continue implementation of the plan for the statewide expansion of HMG. Currently, plans are underway to begin Phase 2 of the expansion which includes teaming with several partners to pilot a rural area expansion in Carbon, Vernal and Duchesne counties. The Division believes that HMG has the potential to be an umbrella service that could link multiple early childhood programs and services and integrate them with ongoing developmental screening among other services.

The Parent Support Programs Manager will continue to work with Utah's local health departments on the use of the ASQ in targeted case management. Utah's local CCR&R agencies will continue to offer periodic Career Ladder training on developmental screening using the ASQ.

State Performance Measure 6: *The percentage of students who smoked cigarettes; smoked cigars, cigarillos, or little cigars; or used chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				10.6	7.8
Annual Indicator		10.7	10.7	7.8	7.8
Numerator		164	164	127	127
Denominator		1533	1533	1628	1628
Data Source		See footnote	See footnote	See footnote	See Footnote
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	7.8	7.8	7.7	7.7	7.6

Notes - 2012
Numerator: YRBS, 2011, survey sample data
Denominator: YRBS, 2011, survey sample data

Notes - 2011
Numerator: YRBS, 2011, survey sample data
Denominator: YRBS, 2011, survey sample data

Notes - 2010
Numerator: YRBS, 2009, survey sample data
Denominator: YRBS, 2009, survey sample data

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was to reduce high school tobacco use to 7.8% and the Annual Indicator was 7.8% (Source 2011 YRBS).

Health Communication Interventions: The Utah Tobacco Prevention and Control Program (TPCP) used a variety of media types and messages to counter tobacco industry advertising. FY12 television and print ads featured graphic and emotionally hard hitting images and messages to prevent youth tobacco use.

Cessation Interventions: The TPCP continued to offer tobacco cessation services for youth through a group program for youth cited for tobacco possession (Ending Nicotine Dependence) and telephone counseling (Utah Teen Tobacco Quit Line).The Quit Line counselors were trained in youth-oriented motivational interviewing and focused on helping youth tobacco users to quit by assisting them with moving through the stages of change.

Community Interventions: The TPCP partnered with local health departments and school districts to strengthen tobacco-free policies in schools and communities and to improve school-based prevention education. The TPCP provided schools and communities with accurate information about new addiction-forming tobacco products such as dissolvable tobacco, e-cigarettes, and hookahs. One Good Reason, Utah's statewide anti-tobacco youth group, educated Utahans about new, dissolvable tobacco products that resemble breathe mints and strips. The composition, packaging, and flavoring of these products might be particularly appealing to children. Youth groups around the state provided peer-to-peer education and grassroots marketing for youth who are increased risk for tobacco use. The TPCP partnered with local health departments to conduct an average of three compliance checks in each tobacco retail outlet. In addition to civil penalties, outlets not in compliance with laws that prohibit sales to minors received educational interventions to assist with preventing future sales to underage youths. To lower the rate of noncompliance and to educate retailers about Utah's tobacco access laws, local health departments shared educational materials and conducted trainings.

Evaluation: The TPCP worked with an independent evaluation team to conduct telephone surveys to evaluate anti-tobacco media campaigns. Survey results were used to inform prevention programming. For cessation interventions, the TPCP tracked enrollment, as well as satisfaction and quit rates. Community interventions were evaluated through standardized surveys for policy development, educational strategies, and public opinion regarding tobacco related topics. Since 2002, 21 of Utah's 41 school districts worked with TPCP and local health departments to strengthen tobacco-free school policies, tobacco education, and policy enforcement. These districts served nearly 220,000 students in 469 schools. Since 2001, illegal tobacco sales to underage youth during compliance checks declined by 69%. At 5.0%, the rate of non-compliance was at its lowest recorded level.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Utah Tobacco Prevention and Control Program (TPCP) used a variety of media types and messages to counter tobacco industry advertising.			X	
2. The TPCP continued to offer tobacco cessation services for youth through a group program for youth cited for tobacco possession.			X	
3. The TPCP partnered with local health departments and school districts to strengthen tobacco-free policies in schools and communities and to improve school-based prevention education.			X	
4. The TPCP worked with an independent evaluation team to conduct telephone surveys to evaluate anti-tobacco media campaigns.				X
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
Health Communication Interventions: The TPCP will continue to prevent youth tobacco use through anti-tobacco advertising in a variety of media. For television, following national research findings, adult cessation ads that also resonate with youth were selected for the youth media market.

Cessation Interventions: The TPCP offers tobacco cessation services for youth through a group program for youth cited for tobacco possession (Ending Nicotine Dependence) and free telephone counseling (Utah Teen Tobacco Quit Line).

Community Interventions: The TPCP partners with local health departments and school districts to develop and strengthen tobacco-free policies in schools and communities. The TPCP provides information about new tobacco products such as e-cigarettes and hookahs. TPCP's anti-tobacco youth coalition "One Good Reason" provides peer-to-peer education and grassroots marketing for youth who are increased risk for tobacco use.

Evaluation: In addition to telephone surveys to evaluate anti-tobacco media campaigns, the TPCP partners with RTI to conduct an online study of youth who are smokers or susceptible to tobacco use. Youth are being recruited at alternative schools and through the TPCP's disparities networks. For cessation interventions, the TPCP tracks enrollment, satisfaction and quit rates. Community interventions are assessed through standardized surveys for policy development, educational strategies, and public opinion regarding tobacco-related topics.

c. Plan for the Coming Year
The Utah Tobacco Prevention and Control Program (TPCP) will continue to use the Centers for Disease Control and Prevention's Best Practices for Comprehensive Tobacco Control Programs as a guideline to plan interventions to decrease tobacco use among youth. The TPCP will use national media research and findings from an online study with Utah youth who are susceptible to smoking to select prevention strategies and media messages to prevent initiation of smoking among youth and to encourage youth smokers to quit. Results will be evaluated through telephone and online surveys.

In addition to promoting tobacco-free norms and policies through community partnerships, the TPCP's community interventions will focus on youth access to tobacco products and point of sale advertising. The local health department-led tobacco retailer education and compliance check program will be expanded to include reviews of retail-based tobacco advertising practices near schools, tobacco retail density, and tobacco pricing strategies. The reviews will guide the local health departments in local efforts to restrict tobacco advertising, pricing discounts, and limit the density of tobacco retail outlets near schools and other areas frequented by children and teenagers.

The program will work with local health districts to strengthen the statewide youth coalition that was formed last year. This group will use a youth-led statewide coalition model to increase visibility of the youth anti-tobacco movement and assist with tobacco policy change.

In FY2013, local health departments will resume overseeing comprehensive school tobacco policy changes with the remaining school districts. School districts will be selected based on high tobacco use rates in their areas.

The TPCP will continue to monitor experimentation and use of traditional and emerging tobacco products and work with partners to identify strategies to prevent youth tobacco addiction.

State Performance Measure 7: *The percent of youth during the last 12 months who feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	25.9	25.9	25.5	25.9	26.7
Annual Indicator	25.9	26.0	26.0	26.7	26.7
Numerator	499	408	408	450	450
Denominator	1926	1569	1569	1687	1687
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	26.6	26.6	26.5	26.5	26.4

Notes - 2012
Numerator: YRBS, 2011
Denominator: YRBS, 2011

Notes - 2011
Numerator: YRBS, 2011
Denominator: YRBS, 2011

Notes - 2010
Numerator: YRBS, 2009
Denominator: YRBS, 2009

a. Last Year's Accomplishments
The Performance Measure was achieved. The Annual Performance Objective was 26.7% and the Annual Indicator was 26.7%.

The Violence and Injury Prevention Program (VIPP) continued to provide data collection and analysis services on Utah suicides (suicide fatalities, suicide emergency room visits, and suicide hospitalizations) to partners and the media. VIPP also developed a state plan for injury in which suicide prevention is a priority for youth 15 to 19 years of age. Staff also participated on the Utah Suicide Prevention Coalition. VIPP continued to facilitate the state Child Fatality Review Committee (CFRC) in which the Division's Medical Director also attended and participated.

The Child Injury Deaths in Utah report was produced which breaks down child deaths by age, sex, geographic location, and circumstances and includes a section on youth suicides. The report also provided recommendations for prevention of these deaths.

VIPP responded to 16 media requests on suicide in FY12 and continued to serve as a primary source of data on suicides across the lifespan.

The Utah National Alliance on Mental Illness (NAMI) continued to provide the Hope For Tomorrow Program, a mental health education program which brings together the combined efforts and insights of mental health professionals, educators, and other experts to help parents,

teachers, students and communities understand mental illness.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Violence and Injury Prevention Program (VIPP) provided data collection and analysis services.				X
2. VIPP developed a state plan for the prevention of suicide for ages 15 to 19.			X	
3. VIPP co-chaired the Utah Suicide Prevention Coalition.				X
4. VIPP facilitated the Child Fatality Review Committee (CFRC) which reviewed all child deaths under age 18 in the state.				X
5. Utah NAMI continued its Hope For Tomorrow Program.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Violence and Injury Prevention Program (VIPP) continues to provide data collection and analysis services, utilizing the National Violent Death Reporting System and Child Fatality Databases in this process. VIPP staff also is participating in the development of a plan to prevent suicide among youth ages 15 to 19 and remains co-chair of the Utah Suicide Prevention Coalition. A school health consultant was hired during this fiscal year and serves on the Child Fatality Review Committee and the Utah Suicide Prevention Coalition.

Five new fact sheets on suicide across the lifespan (youth, young adult, women, men, and older adults) have been produced and disseminated. A news release was also sent to local media in conjunction with the fact sheets' release in partnership with the Department of Human Services. From July 1, 2012 to March 25, 2013, VIPP has responded to 15 media requests on suicide. VIPP is seeing an increasing interest in suicide among stakeholders, the media, and policymakers as evident from the number of data and presentation requests, media stories, and legislation targeting prevention of suicides, in particular youth suicides. VIPP and Department of Human Services Division of Substance Abuse and Mental Health staff gave several presentations on suicide prevention to local school districts and community groups. VIPP also is updating the suicide webpages on the VIPP website to reflect current trends, circumstances surrounding suicides, and prevention tips.

c. Plan for the Coming Year

VIPP will co-chair the Utah Suicide Prevention Coalition with the Youth Suicide Specialist at the Division of Substance Abuse and Mental Health in the Department of Human Services. VIPP will also participate on the policy subcommittee of the Coalition. VIPP will take a lead role in developing a new Utah Suicide Prevention Plan. VIPP will continue to provide data collection, analysis and fact sheet publication and dissemination to community partners, the media, and policy makers. VIPP will utilize the National Violent Death Reporting System and Child Fatality Databases for data collection and analysis.

VIPP will continue to facilitate the Child Fatality Review Committee (CFRC) which conducts reviews of all child deaths under age 18 in the state. All youth suicides are reviewed in-depth by the CFRC. Recommendations for policy and system changes, education, and interventions will be

given by the CFRC to prevent future deaths like the ones reviewed.

Many of Utah's 12 local health departments (LHDs) have recognized the growing problem of suicide in their communities. VIPP staff will work closely with the LHDs to develop activities in their contracts that address youth suicide. Examples of activities the LHDs will undertake in FY14 include participating on their local prevention coalitions, holding youth prevention summits, working with Utah's Native American tribes, implementing the safeTALK program, promoting the National Suicide Prevention Lifeline, engaging community leaders, utilizing local media to di-stigmatize mental illnesses and suicide, attending trainings, etc. VIPP will also leverage funding from a CDC grant to have two staff be trained as Master Trainers for an evidence-based suicide prevention program such as the Question Persuade Refer (QPR) program or Mental Health First Aid.

VIPP hopes to continue efforts to reduce youth suicide, but the extent of involvement will be dependent on resources.

State Performance Measure 8: *Percentage of students who were physically active for a total of at least 60 minutes per day on five or more of the past 7 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				47.5	48.5
Annual Indicator		47.3	47.3	48.5	48.5
Numerator		744	744	811	811
Denominator		1572	1572	1672	1672
Data Source		See footnote	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance Objective	48.5	48.7	48.9	49.1	49.3

Notes - 2012
Numerator: YRBS, 2011
Denominator: YRBS, 2011

Notes - 2011
Numerator: YRBS, 2011
Denominator: YRBS, 2011

Notes - 2010
Numerator: YRBS, 2009
Denominator: YRBS, 2009

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 48.5% and the Annual Indicator was 48.5%.

The Gold Medal School program (GMS), a school-based offshoot of the A Healthier You Legacy Awards Program, continued to help elementary schools set up policy and environmental supports making it easier for students and staff to be physically active and eat healthy food.

The "Unplug 'n Play" program continued to encourage students and their families to limit TV and

other screen time to less than two hours per day. In April 2012, the PANO program participated in the Unplug n' Play and the National TV Turn Off Week projects. The PANO program provided Parent Teacher Associations information focused on family activities other than TV, computer games, or other screen-related activities.

Walk to School Day was promoted in the first week of October 2011 to encourage students and their parents to walk to school safely. The goal of this project was to encourage regular walking or cycling to school throughout the year. Information was shared with local Parent Teacher Associations. The information focused on how to support parents and students walking or cycling to school.

Action for Healthy Kids (AFHK) continued to bring partners together to improve nutrition and physical activity environments in Utah's schools by implementing school-based state plan strategies. In FY11, the Utah Physical Activity and Nutrition (U-PAN) school workgroup was integrated with AFHK to strengthen the efforts with partners. AFHK completed activities in the U-PAN State plan and Utah's AFHK action plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Physical Activity, Nutrition and Obesity Program (PANO) developed policies through Gold Medal Schools program.				X
2. Unplug 'n Plan encouraged students and their families to limit screen time.			X	
3. Walk to School day encouraged regular walking and biking to school throughout the year.			X	
4. The Utah Physical Activity and Nutrition (U-PAN) Schools workgroup integrated with Action for Healthy Kids (AFHK).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Utah Department of Health (UDOH) Physical Activity, Nutrition and Obesity Program (PANO) continues to work on programs to promote increased healthful eating and regular physical activity to prevent and control obesity and other chronic diseases among Utah youth. Most of the PANO program activities target policy, systems, and environmental changes at the state level. They also provide technical assistance to local health departments to implement community-level specific change, supported by individual behavior change programs.

The following activities are being implemented. (1) The Gold Medal School Program continues to help elementary schools establish policy and environmental policies that enable students and staff to be physically active and eat healthful food. (2) The "Unplug 'n Play" program encourages students and their families to limit TV and other screen time to less than two hours per day. (3) Walk to School Day encourages students and their parents to walk to school safely. (4) Body mass index trends are tracked in a sample of elementary students to see how Utah students compare to national students. (5) The Action for Healthy Kids coalition continues to work towards improving the nutrition and physical activity environments in Utah's schools.

c. Plan for the Coming Year
The Utah Department of Health (UDOH), Physical Activity, Nutrition and Obesity Program (PANO) will be merging with the Heart Disease and Stroke and Diabetes programs in FY14 under a new Federal FOA. This new yet unnamed public health program will continue to work on interventions that promote increased healthy eating and regular physical activity to prevent and control obesity and other chronic diseases among Utah youth. Most of the program activities will center on policy, systems, and environmental changes to increase healthy eating and physical activity in K-12 schools.

(1) Proven effective school programs will be available to help elementary schools set up policy and environmental supports that make it easier for students and staff to be physically active and eat healthy food. The UDOH will continue to partner with the Utah State Office of Education, the Utah Parent Teacher Association and Action for Healthy Kids to assist schools in selecting proven effective programs to meet the required objectives.

(2) The "Unplug 'n Play" program will also continue to be implemented. This program encourages students and their families to limit TV and other screen time to less than two hours per day. Recent years have included contests between schools to track the greatest proportion of students who turned off their television for a week, and surveys of school media use policies.

(3) Walk to School Day will be promoted in October to encourage students and their parents to walk to school safely. The goal is to encourage regular walking or cycling to school throughout the year. The UDOH also partners with the Utah Department of Transportation to promote Walk More in Four, a program to promote walking in the four weeks prior to International Walk to School Week/Day.

(4) Height and weight trends will be tracked in a sample of elementary students to see how Utah students compare to the U.S. Students in selected schools within the 1st, 3rd, and 5th grades. This evaluation will identify Utah specific childhood obesity data that is representative of elementary school students statewide.

(5) The Action for Healthy Kids coalition will continue to meet with the goal of improving nutrition and physical activity environments in Utah's schools by implementing school-based U-PAN state plan strategies.

State Performance Measure 9: *The percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12	12	11	5.5	4
Annual Indicator	10.6	10.4	5.2	4.0	2.8
Numerator	2333	2305	1190	1083	798
Denominator	21978	22080	22745	26880	28039
Data Source	See footnote for source	See footnote for source	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final
	2013	**2014**	**2015**	**2016**	**2017**
Annual Performance	2.8	2.8	2.8	2.8	2.8

Objective					

Notes - 2012
Numerator: The number of children served in the rural area based on the CSHCN billing system, 2012.
Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

Notes - 2011
Numerator: The number of children served in the rural area based on the Mega West billing system, 2011.
Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2009/2010 survey, 13.0% estimate.

Notes - 2010
Numerator: The number of children served in the rural area based on the Mega West billing system, 2010.
Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 4.0% and the Annual Indicator was 2.8%.

Flat Federal and State funding, a 10% increase in specialty provider contract fees, along with an increasing rural population of children and youth with special health care needs continued to present major challenges in maintaining service delivery and achieving the performance measure. Service reductions led to an inability to maintain the same level of service as previous years. Although good portions of some services were cut, special attention was given to determining the most effective changes and cuts to make, in order to ensure the continued service provision of the most viable types of care in the most underserved areas. Despite these funding problems, efforts were made to continue to focus on providing the highest level of care possible to the children in rural areas of Utah. Service delivery plans focused on bringing the types of providers and services most in demand in the areas with the State with the greatest need.

Children with Special Health Care Needs (CSHCN) continued contractual agreements with two local health departments and with Intermountain Healthcare to provide clinics at six different sites throughout the state. The contracts provided for RN care coordinators and clerical support staff to schedule clinics, manage care coordination services, arrange tests, collect reports and maintain and manage patient charts as well as office and clinic space. CSHCN provided training and support in the areas of care coordination, patient, chart and workload management. CSHCN implemented our new electronic health record (EHR), CaduRx, providing statewide training on the new system. We also continued to provide ongoing support for existing local client database software and billing programs, transitioning to the new system, and chart tracking and management procedures and protocols. Despite a cost increase, contracts with the Department of Pediatrics at the University of Utah were re-negotiated and extended to provide consistent pediatric, sub-specialty evaluation services for these clinics.

The Bureau continued the use of our referral form, available on-line to solidify close coordination with primary providers. CSHCN was able to maintain its efforts to support the statewide Medical Home effort and provided close contact and coordination with local primary care medical home providers surrounding optimal care for children. The Bureau continued to support and promote collaboration and coordination between the rural clinics, pertinent CSHCN programs and ancillary agencies often involved the special populations served by the clinics, which included the Neonatal Follow-up Program, Specialty Services; Fostering Healthy Children and Baby Watch

Early Intervention programs. CSHCN continued its agreement with Intermountain Healthcare, the primary health care provider system in the State, to allow for access to their electronic health records (EHR) system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN engaged in service delivery planning and reorganization services and resources in response to provider cost increases.				X
2. CSHCN continued contractual agreements to provide clinics at six different rural sites.		X		
3. Local RN and office support staff provided clinic coordination, scheduling, management, chart maintenance, and follow-up for each clinic.		X		
4. CSHCN continued support and training for all outlying staff covering care coordination, patient and chart management involved in the transition to our CaduRx electronic medical record system.				X
5. CSHCN continued to support and assist local clinics in coordination with the statewide Medical Home effort, other pertinent CSHCN programs, and care management efforts with local primary care providers.				X
6. CSHCN maintained ongoing use of referral form available on-line, to better facilitate communication and coordination with primary health providers.		X		
7. CSHCN continued an agreement to gain access to electronic medical records maintained by the primary health care system in the State.				X
8. CSHCN implemented CaduRx EHR system statewide, moving toward meeting Meaningful Use requirements for the system.				X
9.				
10.				

b. Current Activities

Flat State and Federal funding, along with increases in provider contract costs, continue to take a toll on the provision of services to the rural communities. Even with staff and service reductions, CSHCN Bureau is continuing its efforts to provide optimal care and services to rural children with special health care needs through specialty clinics.

CSHCN contracts with 2 local health departments and other agencies to conduct itinerant clinics in six sites in the state. Close scrutiny of the need for specific clinical services continues to support changes leading to cost-containment. In response to pending funding cuts on the Federal level, the Bureau has begun a targeted service planning effort to focus on maximizing provision of services to the most needy of children and families in the areas with most demand and least availability. We entered into a collaborative effort with the Oral Health Program to provide access to dental hygiene education and services for our clients at our rural clinics.

Through the use our on-line referral form, CSHCN continues to promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, working with local primary care medical home providers to coordinate the care and access to resources for children. Care coordination is facilitated via access to private electronic health (EHR) records, along with

the formal implementation of our own EHR system, CaduRx, in all of our clinics statewide.

c. Plan for the Coming Year
Funding challenges will continue to plague our ability to provide CSHCN services, especially in rural clinics. Regardless of the loss of staff and services due to these challenges, CSHCN will continue to contract with local health departments and other entities to conduct itinerant clinics in six sites across the state. CSHCN will continue ongoing needs assessment and targeted strategic planning in order to evaluate the need for services by location and to maintain the services most in demand at sites with increasing populations. Through these contracts, local registered nurse care coordinators and clerical staff will schedule and conduct clinics, provide care coordination services, arrange tests, collect reports and maintain hard copy and new electronic medical charts. CSHCN will provide ongoing consultation and support on care coordination issues to contract staff, along with training in these areas. CSHCN will work on Meaningful Use attestation for the electronic health records (EHR) system used at each site to schedule clinics, collect patient data, maintain and billing, by providing all pertinent staff training, assistance and consultation as needed to meet the Federally required criteria.

CSHCN will promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort and will work closely with local primary care medical home providers to further enhance our referral process and use of the referral form to better coordinate the care and access to resources for children. Additionally, rural nurses will continue to collaborate, and be assisted in doing so, with other CSHCN staff in rural Utah, including the staff from the Fostering Healthy Children Program and Specialty Services. These efforts will provide opportunities for community providers to join and interact with CSHCN clinical staff regarding specific care management issues. Efforts with the Emergency Medical Services for Children (EMS-C) and the Oral Health Program will continue in order to maximize the types of services and care for our patients.

The CSHCN Bureau will continue its efforts to optimize services in the face of increasing population challenges and costs. Collaboration and contracting with entities from the University of Utah will be scrutinized and adjusted to optimize the use of their sub-specialists at our clinics. Additionally, CSHCN, in concert with the use of our new EHR , will continue its efforts to collaborate with the CHARM, UHIN, CHIE and private EHR entities to move toward clinical information sharing between viable systems.

State Performance Measure 10: *The percentage of children (birth -17) eligible for Medicaid DM who are eligible for SSI.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective				85	92.5
Annual Indicator		75.0	92.5	92.0	96.3
Numerator		3821	4899	5070	5502
Denominator		5093	5295	5511	5715
Data Source		See footnote for data source	See footnote	See footnote	See footnote
Is the Data Provisional or Final?				Final	Final

	2013	2014	2015	2016	2017
Annual Performance Objective	96.3	96.3	96.3	96.3	96.3

Notes - 2012
Numerator
UDOH Medicaid Data Warehouse, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type
Denominator
Number of unique children (0-17) receiving SSI during spedific month by age (December). Social Security Report

Notes - 2011
Numerator
UDOH Medicaid Data Warehouse, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type.

Denominator
SOURCE: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table—Number and percentage distribution of children in Utah receiving federally administered SSI payments, by selected characteristics, December 2010.

Notes - 2010
Numerator
UDOH Medicaid Data Warehouse, Medicaid Eligibility Data, Children ages 0 -17. Data by age served, by D Medicaid and by aid type.

Denominator
SOURCE: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table—Number and percentage distribution of children in Utah receiving federally administered SSI payments, by selected characteristics, December 2010.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 92.5% and the Annual Indicator was 96.3%.

The CSHCN Utah Family Voices (UVF) Director and the MCHB-funded Family to Family Health Information Center (F2F) staff provided information about the importance of comprehensive health insurance financing for families of children with complex and chronic conditions. This information included an explanation of the Medicaid program and all the eligibility categories, especially the disability category, the Social Security Income (SSI) resources and the link between programs that a family may potentially be eligible for. The information and referral to the appropriate agency was included in every activity including individual consultations, workshops, displays and information booths, conference presentations and printed materials.

The information provided to individual families or professionals was tracked through a database developed especially to capture data points of the six core outcomes for children and youth with special health care needs along with information and activities by the F2F project. The process of providing assistance to any contact made to the CSHCN UFV Director or the F2F was screening for access to adequate health insurance for the needs of the child or children. Referrals were made to specific intake workers that understand the unique needs and issues of families of children with special health care needs throughout the state if appropriate. The intake workers that the staff commonly referred to are located at Primary Children's Medical Center and specific schools in districts across the state.

All children seen in the CSHCN clinics and programs were referred to the Bureau SSI specialist

who is bi-lingual to look at eligibility for Medicaid including the disability category and SSI. Information and application assistance were provided for families in Spanish through the specialist. The F2F and the Utah Parent Center (UPC) provided a designated Spanish telephone line and staff person to help families with special health care needs and disabilities needing assistance in their language. All applicable parents were referred to the Bureau SSI specialist as a process of helping Spanish-speaking parents address potential eligibility and access to Medicaid and SSI for their health care financing needs.

Information was provided through the majority of statewide workshops and presentations delivered to families and professionals about the resources that exist for health care financing. All of the information delivered included key information about Medicaid in general and the disability category and its relation to SSI. The focus was on educating families and professionals about the disability category and helping them to advocate at intake to look at potential eligibility due to the difference in population, eligibility of the program and its intent to meet the health care needs of children with disabilities.

Ongoing information about the disability category of Medicaid was included in electronic newsletters, social media sites and printed materials from the F2F Center. Updated information on health care financing including Medicaid Disability education was placed on the Family pages of the Medical Home Portal. A key fact sheet on the explanation on EPSDT and the importance of medical necessity for children on Medicaid was updated in collaboration with staff at Medicaid. The fact sheets on the Medicaid disability program and the EPSDT benefits for children on Medicaid were provided at every display booth and information fair that the F2F attended.

Annual presentations were provided to participating Medical Home project teams in Learning Sessions, Medical Home Coordinators, and multidisciplinary trainees involved in the Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND) program to educate about the needs and potential resource that Medicaid and SSI can provide for the families they serve. Additional presentations were given to disability specific organizations, conferences and ongoing workshops provided, Medicaid information is always embedded in all materials presented in hopes of reaching eligible children and their families.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Families received individual consultation regarding potential SSI, Medicaid and the Disability category from the F2F project.		X		
2. Families received information and application assistance in both Spanish and English for Medicaid Disability and SSI from CSHCN Bureau staff.		X		
3. Families and professional received electronic information and printed materials about SSI, Medicaid and EPSDT at conferences, presentations and trainings.		X		
4. Agencies, organizations and other professionals were provided in-services on the resources available to families from Medicaid and the potential relationship of the Medicaid Disability program and the Social Security Income (SSI) benefit.				X
5. A database was utilized to track information collected about families served related to health care financing and needs.				X
6. Information was updated and expanded for the Medical Home Portal website to educate pediatric clinicians, families and other allied health professionals about health care financing resources that included Medicaid and SSI.				X

7.				
8.				
9.				
10.				

b. Current Activities
The CSHCN UFV Director and the F2F staff are providing Care Notebooks to families and information about the benefit of effective record keeping when applying for resources and services such as Medicaid and SSI. A Spanish version of the Care Notebook was developed and is being reviewed and updated. Information for families with linguistic differences including those who are deaf is being added into materials and presentations.

Intake workers with expanded knowledge of the unique challenges faced by families from the Department of Workforce Services are continually being identified and relationships are being built in efforts of helping the families experience a seamless service system. Identifying the key intake workers throughout the state is enabling families to get timely, accurate information to complete applications and potential eligibility of essential services for children with special health care needs.

Ongoing publication of materials with education about Medicaid Disability, Social Security Income and other relevant public and private health care resources are distributed in collaboration with disability groups and organizations. Materials that are developed are shared with Parent Partners in the Medical Homes and Specialty Clinics to distribute to families

The CSHCN UFV Director participated in the Utah Department of Health Strategic Planning workgroups to provide input and expertise from families' perspectives of families throughout the state.

c. Plan for the Coming Year
As part of the Affordable Care Act (ACA), Utah Medicaid contracted with four health plans known as Accountable Care Organizations (ACO). The ACOs are managing the care for the Medicaid consumers along the Wasatch Front effective the beginning of 2013. Challenges and opportunities will continually be identified by families of children with special health care needs.

A main focus for the next year will be to collaborate with the ACOs and the Medicaid agency. Some of the mechanisms will be: sharing data collected about themes of challenges, issues and barriers reported by families and health care professionals by CSHCN and F2F staff; Information about the Medicaid disability eligibility category and EPSDT benefits will be developed and shared with families enrolled in ACOs; and presentation materials will be developed for ACOs to share with staff regarding families of children with special health care needs and the unique needs of each child.

With the many changes in health care financing options available due to the implementation of the ACA, the F2F and relevant CSHCN staff will provide comprehensive education to families about those options in relationship to their individual medical needs to help parents make informed decisions based on their specific circumstances. Information developed will be shared with the Office of Health Disparities for assistance in educating families in a culturally and linguistically effective manner. All the materials developed by the F2F will be adapted and provided in Spanish to share with families in CSHCN clinics, Medical Homes and support groups in the Hispanic community to further educate about the disability category of Medicaid, the relationship with SSI and the importance of EPSDT for medically necessary health care services, therapies, medications and equipment.

To address the needs most relevant to families, the F2F will develop focused questions to gather

information on knowledge of SSI, Medicaid disability and waiver programs from individuals seeking information about public and private funding and community-based resources. The information collected will be utilized to develop a guide for families about navigation of Medicaid and ACOs. Education about the Medicaid disability program, Medicaid waiver programs, SSI and EPSDT and the relationship and importance each has to a child with special health care needs will be included.

F2F staff will serve on the Medicaid Advisory Committee to be a representative of families of children with special health care needs. The F2F, CSHCN Family Support, URLEND Family Involvement and Medical Home Parent/Family Partners will collaborate and network to make sure that every family is connected to a Medicaid intake worker that has expertise in Medicaid programs. This will allow for the Disability Determination Services to become involved in a timely manner to process the relevant applications for SSI and Medicaid Disability.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	6.8	7.0	7.0	6.9	6.9
Numerator	3784	3780	3650	3546	3546
Denominator	55605	53894	52164	51144	51144
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2011
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2010
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Utah saw a small decline in the percentage of low birth weight (LBW) births - from 7.0% in 2010 to 6.93% in 2011. Utah's rate was below the 2011 national rate of 8.1% and meets the Healthy

People 2020 goal of 7.8%. Level MCH Block grant funding and a lack of State General funding limit the program's ability to address LBW rates. Utah continues to promote its "Power Your Life" preconception social marketing campaign. The campaign promotes optimal preconception health and interpregnancy intervals. In addition, Utah received over $825,000 in teen pregnancy prevention funds for a five-year period beginning in 2011.Since teens are at higher risk of having premature or low birth weight infants, preventing teen pregnancy may impact rates of LBW.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

The "Power Your Life" social marketing campaign kicked off in July 2010.The campaign targets young women in Utah (special emphasis on younger, racial/ethnic minority women) with important preconception messages. The focal point of the campaign is an interactive website where women can learn about how to achieve optimal health before they conceive. Mass media messages were implemented to drive the target audiences to the website. There is abundant recent research indicating the link between optimal preconception health, appropriate interpregnancy intervals and improved pregnancy outcomes. In addition, contracts for Abstinence Education and PREP programs were implemented in 2011 which is expected to reduce the rate of teen births in Utah and may have an impact on our LBW rates. Because the majority of low birth weight infants are born preterm, Utah's focus on reducing prematurity rates will have an impact on this measure as well.

c. Interpretation of what the data indicate:

The percent of live born infants weighing less than 2,500 grams in Utah has increased slightly over the past decade (2001-6.4% to 2011 6.9%). Several subpopulations of Utah women have higher rates; for example, younger and older women experienced high rates of LBW; women aged 15-19 had a rate of 8.7% in 2011, women aged 35-44 years had a rate of 8.0% compared to women age 20-34 years (6.7%). In addition, Utah Hispanic women had a rate of 7.4% in 2011 compared to non-Hispanic women (6.8%). Lastly, Utah women of color experienced higher rates of LBW than Utah White women (6.7%): Black (15.1%), American Indian (8.3%), and Asian (9.9%). There is a link to prematurity with 72% of low birth weight infants being born prematurely.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	5.2	5.2	5.3	5.2	5.2
Numerator	2791	2736	2690	2585	2585
Denominator	53882	52164	50475	49484	49484
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2011

Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2010
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Please see HSI #01A a.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

The American College of Obstetricians and Gynecologists recommends the use of 17 alphahydroxy- progesterone (17P) beginning in the second trimester of a singleton pregnancy for women with a history of previous preterm birth. The Maternal and Infant Health Program (MIHP) has worked with multiple partners to promote the use of 17P for the prevention of recurrent preterm birth in singleton pregnancies. Pregnant women, who have had a previous spontaneous preterm birth, particularly in the immediate preceding pregnancy, should be offered 17P beginning at 16-20 weeks of gestation. The MIHP continued its campaign to increase awareness among women who have delivered a preterm infant about the option for 17P. Information cards were disseminated across the state. The same information was placed on the MIHP website. Because the majority of low birth weight infants are born preterm, Utah's focus on reducing prematurity rates will have an impact on this measure as well.

c. Interpretation of what the data indicate:

The percent of singleton live births weighing less than 2,500 grams in Utah has remained stable over the past decade fluctuating slightly from 5.0% - 5.4% over the last decade. Due to the small changes in low birth weight among singletons, most changes in the overall rate of low birth weight can be attributed to multiple births. Because 67% of low birth weight singleton infants are born preterm, Utah's focus on reducing prematurity rates will have an impact on this measure as well.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	1.0	1.0	1.1	1.1	1.1
Numerator	577	562	579	554	554
Denominator	55605	53894	52164	51144	51144
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2011
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2010
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

The rate of very low birth weight (VLBW) births has remained stable over the past decade (2000 - 1.1%, 2011 - 1.1%). These infants are extremely fragile with high rates of mortality and long term morbidity, which places extreme burden on the state in terms of costs and resources. Level MCH Block grant funding and a lack of State General funding limit the program's ability to address LBW rates. Utah continues to promote its "Power Your Life" preconception social marketing campaign. The campaign promotes optimal preconception health and interpregnancy intervals. In addition, Utah received over $825,000 in teen pregnancy prevention funds for a five year period in 2011.Since teens are at higher risk of having premature or low birth weight infants, preventing teen pregnancy may impact rates of LBW.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

Utah continues its "Power Your Life" campaign to educate women about the importance of preconception health and adequately spaced pregnancies. In addition, contracts for Abstinence Education and Comprehensive Teen Pregnancy prevention programs were implemented in 2011 which is expected to reduce the rate of teen births in Utah and may have an impact on our LBW rates.

c. Interpretation of what the data indicate:

As previously mentioned, the rate of very low birth weight (VLBW) births has remained stable over the past decade. As with LBW births, several subpopulations of Utah women have higher rates of VLBW. Among age demographics, women aged 40-44 had the highest VLBW rate at 2.04%. Women who reported a pre-pregnancy BMI in either the underweight (1.7%) or obese (1.6%) category experienced significantly higher rates of VLBW births compared to women with a normal pre-pregnancy BMI (0.81%). Women who reported smoking during pregnancy had a higher rate than women who did not (1.73% vs. 1.03%). Lastly, Black women (3.7%) had rates more than three times higher than White women (1.04%). The largest percentage of VLBW births are seen multiple gestations with a VLBW rate of 9.1% in twins and 38.6% in triplets.

A high percent of VLBW infants do not survive. The 2010 birth weight specific mortality rate for VLBW infants was 207.3/1000 births. The biggest risk for mortality is in infants under 500 grams as evidenced by the mortality rate of 852.5/1000 births. The largest percentage of VLBW infant deaths is due to Perinatal Conditions (n=91). These cases are reviewed in our Perinatal Mortality Review Program and findings from reviews indicate that major contributors include an array of social determinants of health.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	0.8	0.8	0.8	0.8	0.8
Numerator	436	399	422	381	381
Denominator	53882	52164	50475	49484	49484
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2011
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2011

Notes - 2010
Data reported are the most recent data available.

Numerator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010
Denominator: Office of Vital Records and Statistics, Birth Certificate database. UDOH, 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Please see HSI #02A, a.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

Please see HSI #02A, a.

c. Interpretation of what the data indicate:

Please see HSI #02A, a.

The percent of singleton live births weighing less than 1,500 grams in Utah has remained relatively stable over the past decade (2001-0.76%, 2011-0.77%).Risk factors for VLBW singletons mirror those of all VLBW infants.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	7.6	6.9	6.4	8.3	8.3
Numerator	55	51	48	62	62
Denominator	723026	736615	749214	749774	749774
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2011
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, Unintentional Injury, UDOH, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2010
Data reported are the most recent data available.
Office of Vital Records and Statistics, IBIS Injury Mortality Module, UDOH, 2010
Denominator: IBIS Population estimates for 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Utah has 13 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP). Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages 1-14 and their families. Safe Kids members have been advocates for policies and legislation focused on preventing injury among children. VIPP facilitates the Utah Child Fatality Review Committee (CFRC) which conducts reviews of all child deaths under age 18 in the state. Deaths with suspicious circumstances are reviewed in-depth by the CFRC. Recommendations for policy and system changes, education, and interventions are given annually by the CFRC to prevent further child deaths. VIPP continues to fund Utah's 12 LHDs to work on prevention of unintentional injuries among children. The contracts require LHD participation on their local Safe Kids Coalition/chapter. LHDs work on a variety of prevention activities including child passenger safety education to parents and caregivers, car seat inspection stations and checkpoints, distribution and education about ATV/OHV and bicycle helmets, pedestrian and Safe Routes to Schools programs, seat belt education for adolescents, and poisoning and falls prevention. LHDs work closely with state and community partners on these projects.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

Safe Kids is continually looking to attract new partners with similar goals for ages 1-14. Allied

partners, outside of state/local government, have also been helpful when advocating for new laws and when bills are introduced in the legislature. Safe Kids coalitions conduct annual assessments to determine priorities for their areas. VIPP produced the Child Injury Deaths in Utah report which breaks down child deaths by age, sex, geographic location, and circumstances (e.g., ATV deaths, motor vehicle crashes, poisonings, drownings, violent deaths, etc.), as well as provides recommendations for prevention. VIPP has also used local media to promote the report and prevention of unintentional injuries and deaths among children. Most notably, each year VIPP issues news releases on child passenger safety, drowning, and hyperthermia and kids in cars in conjunction with Safe Kids Utah and Utah's only children's hospital, Primary Children's Medical Center.

c. Interpretation of what the data indicate:

Utah's mortality rate of unintentional injuries to children increased 5.9% from a rate of 7.84 per 100,000 in 2010 to 8.27 per 100,000 in 2011, although this difference is not statistically significant. This increase may be due increased drowning and motor vehicle traffic deaths. In 2011, Utah had an extremely wet spring which impacted the number of child drowning.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	4.6	2.2	2.0	2.8	2.8
Numerator	33	16	15	21	21
Denominator	723026	736615	749214	749774	749774
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2011
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, UDOH, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2010
Data reported are the most recent data available.

Office of Vital Records and Statistics, IBIS Injury Mortality Module, UDOH, 2010
Denominator: IBIS Population estimates for 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Utah has 13 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP) and LHD contracts require an active role in the coalitions/chapters. Annual educational efforts and Safe Kids Week activities focus on preventing injuries among children ages 1-14 and their families, with a majority of the activities focusing on car seat and booster seat education, seatbelt education, and bicycle and pedestrian safety. Safe Kids members have been good advocates for any necessary changes in laws being focused on preventing motor vehicle related deaths and injury among children. Safe Kids Coalitions/chapters conduct regular car seat inspections and checkpoints, distribute low-cost seats to families in need, and provide car seat installation classes to community members particularly those in underserved areas.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

VIPP provides funding to Utah's 12 LHDs. LHDs have been able to leverage additional resources provided by the Utah Highway Safety Office and Safe Communities grants to enhance child passenger safety efforts (e.g., purchasing low-cost car seats and booster seats and bicycle helmets for families in need). MCH Block Grant funding is vital to this process, as it provides the bulk of funding for their activities. Many LHDs have begun implementing a Click it Club program for adolescents that focus on seat belts.

c. Interpretation of what the data indicate:

Utah's mortality rate of child motor vehicle fatalities has increased by 7.3%, from 2.6 per 100,000 in 2007 to 2.8 per 100,000 in 2011, although this difference is not statistically significant. Utah also gathers ED data which, combined with hospitalization data, continue to give partners a good understanding of where problems exist. Motor vehicle crashes include five indicators motor vehicle traffic occupants, motorcyclist, pedal cyclist, pedestrian, and other/unspecified.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	13.2	13.1	9.1	10.5	10.5
Numerator	60	59	42	48	48
Denominator	455836	451656	459367	457721	457721
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2011
Data reported are the most recent data available.
Numerator: Office of Vital Records and Statistics, IBIS Injury Mortality Query, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2010
Data reported are the most recent data available.
Office of Vital Records and Statistics, IBIS Injury Mortality Module, 2010
Denominator: IBIS Population estimates for 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

In 2006, traffic safety professionals from across Utah attended a national roundtable on teen driving sponsored the Safe States Alliance. The result was the creation of the Utah Teen Driving Task Force in 2007, chaired by the Violence and Injury Prevention Program (VIPP) and Utah Department of Public Safety. The Task Force brings together stakeholders with an interest in teen driving to ensure activities and resources are coordinated throughout the state. Teen drivers have also been a priority for LHD contracts, funded by VIPP for more than five years. LHD contracts have yielded positive results, with increased seat belt use rates in most health districts, more than 160 events held educating approximately 22,000 Utah teens and 1,300 parents. All participating partners use the "Don't Drive Stupid" and Zero Fatalities campaign slogans and messaging. For the past five years, VIPP has worked closely with families who have lost a teenager in a motor vehicle crash to tell their stories in a memorial booklet. VIPP meets personally with the families, provides grief resources, and helps spread their messages to young drivers. An estimated 5,000 printed memorial books have been distributed and 60,000+ downloaded from the VIPP website since the first memorial book was published in 2008.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

The Utah Teen Driving Task Force meets monthly. The Task Force is supportive of the "Don't Drive Stupid" campaign's media contest, which includes a poster and YouTube video contest. The winning posters are assembled into a calendar and the winning video is shown in movie theaters. The Task Force has also begun work on developing a parent education program. LHDs conduct seat belt observation studies and promote seat belt use among teens. The "Alive at 25" program has also been integrated into county court systems for teens who receive a traffic safety violation by the LHDs. This program is a driver's awareness course designed by the National Safety Council for young drivers ages 15-24.

c. Interpretation of what the data indicate:

Utah's rate of motor vehicle deaths for those aged 15-24 has decreased by 39%, from 17.23 per 100,000 in 2007 to 10.49 per 100,000 in 2011 when the Utah Teen Driving Safety Task Force was formed. This decrease is statistically significant and a major public health victory. This decrease can be attributed to the combined efforts of the partners in a statewide educational campaign and changes in Utah's driving laws, most notably Utah's Graduated Driver Licensing laws which were first passed in 1998. Motor vehicle crashes include five indicators: motor vehicle traffic occupants, motorcyclist, pedal cyclist, pedestrian, and other/unspecified.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	124.6	124.6	116.9	5,850.0	5,850.0
Numerator	901	918	876	43404	43404
Denominator	723026	736615	749214	741951	741951

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
* Data based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined to report for this measure.

Numerator: Hospital Discharge Database Injury Query Module, 2010
Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 119.7 per 100,000 (N=888, D=741951) for 2010.

Notes - 2011
* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 119.7 per 100,000 (N=888, D=741951) for 2010.

Notes - 2010
Data based on Hospital Discharge Database.
Numerator: Hospital Discharge Database Injury Query Module, 2010
Denominator: IBIS Population estimates for 2010

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=45341 & rate=6155 per 100,000

Narrative:
a.

Utah continues to be one of the states with the highest number of young children per family. LHD contracts with the Violence and Injury Prevention Program (VIPP) require an active role in Safe Kids coalitions/chapters. LHDs work on child passenger safety education, car seat inspections, distribution o ATV/OHV and bicycle helmets, pedestrian safety, seat belt education for adolescents, and poisoning prevention. VIPP facilitates the Utah Child Fatality Review Committee (CFRC) and Domestic Violence Fatality Review Committee (DVFRC). Recommendations for policy and system changes, education, and interventions are given annually by the CFRC and DVFRC to prevent further child deaths and injuries. VIPP has also provided the Student Injury Reporting System (SIRS) for more than 30 years to the State Office of Education, local school districts, and local schools. More than 90% of all public schools participate in the SIRS, which tracks injuries on school property or during school-sponsored events. Data are used by school administrators to make policy and environmental changes to prevent further student injuries. VIPP provides fact sheets and district-specific data to school administrators to aid in this process.

b.

VIPP converted the SIRS from a paper-based surveillance system to an online database. This led to increased participation among schools, faster and more accurate reporting, and the possibility of expanding the SIRS to integrate with other programs such as the Asthma and Diabetes Programs. Feedback from users has been extremely positive. Safe Kids is continually looking to attract new partners with similar goals for children ages 1-4. Safe Kids works closely with traffic safety and poisoning prevention partners such as the Utah Department of Public Safety Highway Safety Office and Utah Poison Control Center. Safe Kids coalitions conduct annual assessments to determine priorities for their areas, in addition to data provided by the VIPP. All VIPP data fact sheets include small area data. VIPP uses local media to promote the prevention of unintentional injuries and deaths among children. VIPP issues news releases on child passenger safety, drowning, and hyperthermia and kids in cars, suicide prevention, domestic violence and sexual abuse prevention, ATV/OHV safety, etc. VIPP is well respected with local media and responsive to all data requests from media and program partners. VIPP staff track and provide weekly updates on all injury and violence related legislation during the legislative session and provide fact sheets to advocates and partners on relevant data and programs.

c.

Utah has seen a 20% decrease in the non-fatal rate of unintentional injuries among children under age 14 in the last five years, from 7347.05 per 100,000 in 2006 to 5849.98 per 100,000 in 2010. Rates are calculated from combined hospital discharge and Emergency Department data.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	33.3	19.4	14.8	244.2	244.2
Numerator	241	143	111	1812	1812
Denominator	723026	736615	749214	741951	741951
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 15.4 per 100,000 (N=114, D=741951) for 2010.

Notes - 2011

* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If only Hospital Discharge data are used then the rate will be 15.4 per 100,000 (N=114, D=741951) for 2010.

Notes - 2010
Data based on Hospital Discharge Database Only.
Numerator: Hospital Discharge Database Injury Query Module, 2010
Denominator: IBIS Population estimates for 2010

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=1984, denominator=736615 (2009 data), & rate=269.3 per 100,000

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Utah leads all states with the number of young children per family. Utah has 13 active Safe Kids Coalitions/chapters in communities around the state. This effort is coordinated through the Violence and Injury Prevention Program (VIPP) and LHD contracts require an active role in the coalitions/chapters. Annual educational efforts, Safe Kids Week, and Child Passenger Safety Week activities focus on preventing injuries among children ages 1-14 and their families with a particular focus on motor vehicle crashes and child passenger safety. Safe Kids members have been good advocates for legislation focused on preventing injury among children; they have also been crucial in protecting the booster seat law from attempts to weaken it. LHDs conducted 53 checkpoints, checked 2,111 child safety seats during community checkpoints or individual appointments at the LHD, and distributed 1,568 low cost car seat or booster seats during FY2012.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

The UDOH, Safe Kids, and other traffic safety partners are continuing to improve motor vehicle safety. Efforts include educating on the value of a primary seat belt law for all ages, the importance of booster seats, and bicycle helmets. The Click it Club program, developed for adolescents to improve seat belt use, is being implemented by many LHDs in conjunction with Zero Fatalities program (under the Utah Department of Transportation). Most LHDs are doing an excellent job in training LHD staff or other staff from community agencies to inspect car seats as a way of expanding available resources. Several Child Passenger Safety Technician trainings were held in rural areas of the state, greatly increasing the LHDs' capacity to conduct child safety seat inspections and checkpoints in the future. These trainings are often coordinated by Safe Kids Utah. Multiple LHDs participated in re-certification trainings for technicians whose certification was close to expiring. In this way LHDs were able to use resources more efficiently by keeping skilled technicians rather than needing to train new individuals.

c. Interpretation of what the data indicate:

Utah has seen a 41% decrease in the rate of non-fatal MV rate of injuries to children under age 14 in the last decade, from 415.83 per 100,000 in 2001 to 244.22 per 100,000 in 2010. Rates are calculated from combined hospital discharge and Emergency Department data. This decrease can be attributed to new laws (e.g., Utah's "Booster Seat" law passed in 2008) and the combined educational campaign efforts of all the partners. Motor vehicle crashes include five indicators motor vehicle traffic occupants, motorcyclist, pedal cyclist, pedestrian, and other/unspecified.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	122.2	70.9	62.5	1,037.8	1,037.8
Numerator	557	320	287	4689	4689
Denominator	455836	451656	459367	451817	451817
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If Hospital Dischage data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

Notes - 2011
* Calculation for the measure has been revised. Rates are based on combined Hospital Discharge Data and Emergency Department Encounter Data. VIPP recommends that both HDD and ED data be combined for more accurate reporting.

Numerator: Hospital Discharge Database and Emergency Department Data, 2010
Denominator: IBIS Population Estimates 2010

** If Hospital Dischage data alone is used, the rate for 2010 will be 65.7 per 100,000 (N=297, D=451817).

Notes - 2010
Data based on Hospital Discharge Database Only.
Numerator: Hospital Discharge Database Injury Query Module, 2010
Denominator: IBIS Population estimates for 2010

*VIPP recommends that both HDD and ED data be combined. If both are counted, numerator=5419, denominator=451656, & rate=1200 per 100,000

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

The Utah Teen Driving Safety Task Force, co-chaired by staff from the Violence and Injury Prevention Program (VIPP), was formed in 2007 to better coordinate activities as well as resources for teen driving across the state. Local health departments, law enforcement, and many other partners have worked hard to educate teens and young adults to adopt safe driving

behaviors. A focus on teen drivers has also been a priority in local health department (LHD) contracts with the VIPP for over five years. All participating partners are operating under one slogan and outreach campaign, Don't Drive Stupid and Zero Fatalities.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

The Utah Teen Driving Safety Task Force meets monthly to better coordinate activities and resources. The Task Force tries to provide a different approach or twist to the annual Don't Drive Stupid Campaign in order to engage more teens. This year a teen video and poster contest for a PSA was conducted and the Teen Memorial booklet was distributed statewide to Driver Education Classes. LHDs also conduct seatbelt observation studies at high schools in their areas and work with law enforcement to promote seat belt use. However, Utah currently only has primary seat belt enforcement for those under 18. The political climate makes it difficult to pursue a primary seat belt enforcement law. Efforts to ban cellphone use while driving for teens under 18 have also failed in recent years, despite Utah having a no-texting law (2010) for all drivers regardless of age. VIPP staff attends the Utah Coalition for Traffic Safety Coalition or CUTS to stay up-to-date on pending legislation and provides weekly legislation updates to partners during the general legislative session.

c. Interpretation of what the data indicate:

Utah's rate of non-fatal motor vehicle injuries for those aged 15-24 has decreased 40%, from 1712.05 per 100,000 (2006) to 1037.8 per 100,000 (2010). This rate was calculated using hospitalization and Emergency Department combined data. This decrease can be attributed to the combined efforts of the partners in a statewide educational campaign and changes in Utah's driving laws, most notably Utah's Graduated Driver Licensing laws which were initially passed in 1998. Motor vehicle crashes include five indicators: motor vehicle traffic occupants, motorcyclist, pedal cyclist, pedestrian, and other/unspecified.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2008**	**2009**	**2010**	**2011**	**2012**
Annual Indicator	12.9	13.4	14.0	14.6	15.9
Numerator	1435	1451	1543	1620	1772
Denominator	110841	108205	110053	110810	111682
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2012 preliminary
Denominator: IBIS Population Estimates 2012 preliminary

Notes - 2011
Data reported are the most recent data available.

Numerator: Bureau of Epidemiology, Utah Department of Health, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2010
Data reported are the most recent data available.

Numerator: Bureau of Epidemiology, Utah Department of Health, 2010
Denominator: IBIS Population estimates for 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention and surveillance capacity efforts. Staff within the Bureau of Epidemiology has improved services with a designated HIV/STD Surveillance Coordinator whose work focuses on surveillance, reports, and data integrity. This shift allows STD prevention staff to conduct more technical assistance activities for local health departments, as well as more education, testing and outreach activities in the community. The Utah Department of Health coordinates with public and private providers offering STD-related services in order to provide consistent access to resources and information. Targeted populations continue to include females 15-19 and 20-24. The Centers for Disease Control funding for prevention, testing, treatment, and local health department support will be impacted by sequestration.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

This indicator assists UDOH programs in monitoring trends in rates, which helps us determine if there are other strategies needed to reduce rates. If we see the rates increasing, we can review programs, strategies, and funding allocations to determine if what we are doing is effective. Staff participates in meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence, although it does allow for STD treatment of minors without parental consent.

Changes in organization at UDOH provide new opportunities for collaboration between programs. As programs continue to integrate and increase collaborative activities, we are discovering additional areas where we can access at-risk populations through connections that other programs and staff have already made, as well as strengthen our efforts to reach these populations statewide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, leading to more comprehensive and successful services by the programs involved.

c. Interpretation of what the data indicate:

Data for 2012 indicate a Chlamydia rate of 15.9 per 1,000 females aged 15 through 19 years old, a 8.9% increase since 2011 with the rate of 14.6 per 1,000 females aged 15-19 years old. The 2012 case increase may be due to several reasons, including an increase in provider and laboratory reporting and a possible increase in Chlamydia testing.

This indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	5.0	4.9	5.5	6.2	6.6
Numerator	2567	2493	2847	3113	3342
Denominator	511628	510434	519153	502558	509257
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012
Numerator: Morbidity Data, Bureau of Epidemiology, Utah Department of Health, 2012 (Preliminary)
Denominator: IBIS Population Estimates 2012 (Preliminary)

Notes - 2011
Numerator: Bureau of Epidemiology, Utah Department of Health, 2011
Denominator: IBIS Population Estimates 2011

Notes - 2010
Data reported are the most recent data available.

Numerator: Bureau of Epidemiology, Utah Department of Health, 2010
Denominator: IBIS Population estimates for 2010

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSI?

Reorganization within the Utah Department of Health (UDOH) has expanded STD prevention and surveillance capacity efforts. Staff and duties within the Bureau of Epidemiology have improved services. There is now a designated HIV/STD Surveillance Coordinator whose work focuses on surveillance, reports, and data integrity. This shift allows STD prevention staff to conduct more technical assistance activities for local health departments, as well as more education, testing and outreach activities in the community. The Utah Department of Health coordinates with public and private providers offering STD-related services in order to provide consistent access to resources and information. Targeted populations continue to include females 15-19 and 20-24 years of age.

The Centers for Disease Control funding for prevention, testing, treatment, and local health department support will be impacted by sequestration.

b. What efforts are being made by the program in developing new strategies for meeting the HSI?

This indicator assists UDOH programs in monitoring trends in rates which helps us determine if there are other strategies needed to reduce rates. If we see the rates increasing, we can review programs, strategies, and funding allocations to determine if what we are doing is effective. Staff participates in meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence, although it does allow for STD treatment of minors without parental consent.

Changes in organization at the UDOH provide new opportunities for collaboration between programs. As mprograms continue to integrate and increase collaborative activities, we are discovering additional areas where we can access at-risk populations through connections other programs and staff have already made, as well as strengthen our efforts to reach these populations statewide. These organizational shifts have also provided unique opportunities to participate in new committees and projects, leading to more comprehensive and successful services by the programs involved.

c. Interpretation of what the data indicate:

Data for 2012 indicate a Chlamydia rate of 6.6 per 1,000 females aged 20 through 44 years, a 6.5% increase from 6.2 per 1,000 females aged 20-44 years in 2011.

This indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends.

F. Other Program Activities

The State Title V agency is involved in many activities that address the needs of mothers and children in the state. With the reorganization of the Department, we have new opportunities to integrate programs that serve mothers and children, to explore new opportunities and to develop new relationships internally and externally. Many of the activities that we engage in have been described in other sections of the Annual Application and Report and the Five Year Needs Assessment documents.

/2012/ We focus on areas of MCH that are not necessarily included in the Performance Measures or our state priorities, such as preconception health and health care, promotion of healthy spacing between pregnancies, review of infant and maternal mortality cases, school health, and others. We are concerned about the lack of focus on the health of mothers because the main focus seems to be on infants. We promote the importance of the mother's health as it directly relates to her own health status, but also the health of any infants she has. We have worked on the Level NICU issue in an attempt to provide information about hospitals that self-designate as Level III when they do not meet the criteria for such designation. Our concern is patient safety - that of the mother and the newborn. If a high risk mother delivers at a facility that is not equipped to care for an infant that is in need of Level III neonatal care, we have done a great disservice to the community. We work to promote the awareness that high risk women need to deliver at a facility that has capacity in maternal-fetal medicine as well as neonatal intensive care capacity.//2012//

/2013/We recently created a half time position to address MCH quality improvement. This work is focused on defining the capacities of tertiary newborn intensive care units since hospitals self-declare as Level III. As we looked at hospitals that self-designate as tertiary units, we noted that some do not necessarily follow the AAP/ACOG guidelines. It is a very sensitive political issue which we hope will result in consensus about needed capacity.//2013//

We work closely with the Baby Your Baby Program (BYB) to promote healthy pregnancies and well children. /2013/We are transferring BYB to Medicaid for oversight. //2013// Through several federal grants, we have had the opportunity to build infrastructure in autism, birth defects, First-Time Motherhood, evidence based home visiting, genetics, leadership, and many others.

/2013/ With our early childhood efforts, we are working closely with the Bureau of Child Development on better integrating the Office of Home Visiting with MCH and CSHCN programs. The Connecticut "Help Me Grow" program is thriving in Utah County and we are exploring how we can support it in the Salt Lake Valley. We are excited about the possibility of having a program in the Salt Lake area. We have done some training and involved staff in the MCH grant planning

process.//2013//

The Department's Center for Multicultural Health has been working with Title V programs to address health disparities among minority populations/communities living in Utah. The Center has expanded staff capacity to better understand different communities in our state which has been beneficial for us as well as the communities. We interface with the Department's Native American Liaison to discuss ways we can better meet the needs of the Native American populations.

/2013/Fostering Healthy Children Program works closely with the Department of Human Services to improve the mental, dental and physical health of children in the foster care system. We are also working with the Bureau of Health Promotion on a CDC grant application to establish a Center for Disability Health. The project will improve the health of adults with disabilities through accessible health promotion that is focused on people with disabilities, such as smoking cessation, asthma and diabetes prevention and improved vaccination rates. //2013//

In 2001, legislation known as Safe Haven was passed to allow a mother not wanting to keep her newborn baby to drop the baby off at a hospital with no questions asked. The Legislation was crafted to help reduce the possibility of infant death due to a mother "discarding" her baby in a dumpster or other places, often leading to the infant's death. The Adolescent Health Coordinator works with the sponsor of the bill and representatives of various agencies to track the progress in assisting women who feel they are not able to care for a baby. Several press conferences have been held, print materials and a hotline have been implemented to address this serious problem. /2012/The legislator who sponsored the original bill was able to get ongoing state general funds to support the work required to promote the program and to support a hotline. The funding will be contracted to a community based private not for profit organization that will be responsible for running the program. The contract has been awarded to the YWCA, a local not for profit organization that had been operating the "hotline". They will be responsible for public awareness activities, distribution of brochures, web site maintenance.//2012//

The Division participates on numerous advisory committees sponsored by other state agencies or private agencies to enable the Title V programs collaborate with vital external partners in their work. Examples include the Child Abuse Prevention Council, Child Care Licensing, and so on. In general the state title V agency has exerted concerted effort to increase its collaborative efforts with private providers, agency partners and professional associations to address the health needs of mothers and children, including those with special health care needs.

As our data capacity has been enhanced, we have expanded our ability to "research" various issues impacting mothers and children in the state. For example, MCH staff is looking at prescription overdose deaths among women who had a pregnancy within the 12 months prior to death. We use data to identify problems and associated factors, strategies to address the issues and tracking to measure progress in our work. Expansion of data capacity has enabled programs to conduct surveys, compile data that are important in identifying a health issue and related factors.

/2012/The new WIC information system will be rolled out by fall of 2011 which will greatly enhance our ability to link other data bases to it. We look forward to when we can use WIC data to review outcomes and health issues for women and children enrolled in WIC.//2012//

/2013/ VISION was successfully rolled out in fall 2011. Due to the diligence of the WIC Director, the processes of system development, user testing, trainings and hardware installation etc. were thorough resulting in a high quality product that easily was rolled out. Local clinic staff is very pleased with the system. //2013//

/2012/The Department of Health has initiated an effort to look into accreditation for the agency. Several meetings have already been held and we believe that our work will play an important role in the process. //2012//

/2013/ The Department continues its move towards accreditation through numerous efforts, such as strategic planning with four goals:
• Utahns are the Healthiest People in the Nation
• Putting Health into Health Care Reform
• Transforming Medicaid
• The Department is a Great Organization
Within the first goal, one area of focus is healthy babies which will enable Utah MCH to share our experiences, data, programs, etc. to move this agenda forward. It is a superb opportunity for us to have the Department focus on this area. We will be able to promote life course, preconception and interconception health, etc. It is a perfect fit for us to have such high level support to better address the issues we have identified over the years for mothers and infants. We are working with the March of Dimes and other partners to focus on this important area.//2013//
/2014/Healthy Utah Babies is the assigned strategic plan goal for MCH and CSHCN. The work is being done by a cross section of Department staff including Medicaid, Health Promotion, Child Development, etc.//2014//

G. Technical Assistance

For Utah's Technical Assistance Needs, please see Form 15.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	5967609	5832700	6238800		6629200	
2. Unobligated Balance *(Line2, Form 2)*	2521991	1148100	2152885		416900	
3. State Funds *(Line3, Form 2)*	12581700	12126800	11571700		12328100	
4. Local MCH Funds *(Line4, Form 2)*	3257004	2931400	2432253		2931400	
5. Other Funds *(Line5, Form 2)*	10259000	11760100	8620000		10372000	
6. Program Income *(Line6, Form 2)*	6404800	4615000	7999700		4543900	
7. Subtotal	40992104	38414100	39015338		37221500	
8. Other Federal Funds *(Line10, Form 2)*	60298300	58848600	61386400		60152600	
9. Total *(Line11, Form 2)*	101290404	97262700	100401738		97374100	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	5870240	5839882	5908287		5042120	
b. Infants < 1 year old	5910108	5764797	5521947		5389238	
c. Children 1 to 22 years old	11751736	10645895	10297338		10366316	
d. Children with	15726864	14697553	15693160		14863979	

Special Healthcare Needs						
e. Others	575156	522873	421606		579647	
f. Administration	1158000	943100	1173000		980200	
g. SUBTOTAL	40992104	38414100	39015338		37221500	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	95000		90000		90000	
c. CISS	124000		0		150000	
d. Abstinence Education	319000		343600		953500	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	49939600		49698600		48448700	
h. AIDS	0		0		0	
i. CDC	1293300		1191000		974800	
j. Education	8527400		6990400		7485600	
k. Home Visiting	0		0		0	
k. Other						
Other			3072800		2050000	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		FY 2013		FY 2014	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	9742362	3187924	10067046		3342758	
II. Enabling Services	17510487	22977045	15923520		21724395	
III. Population-Based Services	5253125	4442341	4539187		4485847	
IV. Infrastructure Building Services	8486130	7806790	8485585		7668500	
V. Federal-State Title V Block Grant Partnership Total	40992104	38414100	39015338		37221500	

A. Expenditures

Please see notes related to each Form.

B. Budget

The Division of Family Health and Preparedness (FHP) is organized to address specific maternal and child health needs through a partnership between State agencies and the public and private sector to form a coordinated statewide system of health care. FHP's Block Grant funds are distributed according to the plan of expenditures contained in this application which is based upon a statewide assessment of the health of mothers and children in Utah. Funding reported within this application/annual report is based on the state fiscal year (July 1 -- June 30).

The amount of state funds that will be used to support Maternal and Child Health programs in FY12 is shown in the budget documentation of the state application. We assure that the FY89

maintenance of effort level of State funding at a minimum will be maintained in FY12 [sec.505(a)(4)].

For each four federal dollars a minimum of three state dollars is specifically designated as match. FHP allocates a total of $12,126,800 of state funds appropriated by the Legislature for MCH activities. A total of $6,615,900 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of $6,293,763. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and combined with other federal and private funding to expand and enhance MCH programs and activities. Programs including Pregnancy Riskline, Fostering Healthy Children, and Baby Watch/Early Intervention, benefit from this use of the state funds. FHP receives private funding which is used to enhance selected programs or projects such as WEE Care and Pregnancy Riskline. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities

FHP assures that at a minimum 30% of the Block Grant allocation is designated for programs for Children with Special Health Care Needs and 30% for Preventive and Primary Care for Children. Special consideration was given to the continuation of funding for special projects in effect before August 31, 1981. Consideration was based on past achievements and the assessment of current needs. Title V funding has been allocated to support these activities which were previously funded [sec.505(a)(5)(c)(i)].

FHP will maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit purposes. Audits are conducted by the state auditor's office following the federal guidelines applicable to the Block Grant. In addition, the State Health Department maintains an internal audit staff who reviews local health departments for compliance with federal and state requirements and guidelines for contract/fiscal matters.

FHP will allocate funds under this title among such individuals, areas, and localities identified in the needs assessment as needing maternal and child health services. Funds are distributed largely according to population, although consideration is given to districts with identifiable maternal and child health needs and factors that influence the availability and accessibility of services. These needs are identified in large part by local communities themselves. There are a number of program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as WIC, Newborn Screening, and Baby Watch/Early Intervention.

The Department negotiates contracts with each of the twelve local health departments encompassing many public health functions, and progress is measured against the achievement of the MCH performance measures. The following MCH activities are included: child health clinics, dental health, family planning, injury prevention, prenatal services, school health, speech and hearing screening, and perinatal, sudden infant and childhood death tracking. The allocation of funds, i.e., contracts, staff, or other budget categories, to meet the maternal and child health needs of the community is left to the discretion of the local health officer. This places the determination of need and the allocation of funds for specific needs at the source of expertise closest to the community. State staff provides local health departments' specific data to assist them in determining community needs. Local health department staff and state staff jointly develop an annual plan to address these needs. Annual reports are required from each local health department to monitor MCH activity and document their achievement in impacting the health status indicators for their local MCH populations.

The FY2014 state budget for FHP was held static but was reduced by just over $120,000 in FY2012. This cut is in addition to the $1.4 million cut taken the previous year. The FY2012 reductions primarily impact the Division's administrative programs. Despite the ongoing budget challenges, the Division continues to allocate all available resources (MCH Block Grant funds,

state funding, Medicaid, other private and public grants, and local funds) to most effectively address the changing maternal and child health needs throughout the state.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.